

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on April 13, 2018. The complaint was substantiated (Intake ID # NC00137426). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children or Adolescents. Summary Suspension issued on 04/11/18.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,	V 108		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

CEO/OWNER

5-04-18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 1</p> <p>the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained for MH/DD/SAS (Mental Health/Developmental Disabilities/Substance Abuse Services) needs of the clients for 6 of 6 audited staff (#2, #3, #6, #9, #10 and the Operations Manager/Group Home Staff). The findings are:</p> <p>Review on 04/10/18 of Staff #3's personnel file revealed: -Date of application on 02/20/18. -No documentation of training in MH/DD/SAS to meet the needs of the clients.</p> <p>Interview on 04/05/18 staff #3 stated: -She did not remember the trainers/instructors. -She didn't remember any training specific to MH/DD/SAS.</p> <p>Review on 04/10/18 of Staff #2's personnel file revealed: -Date of application on 02/20/18. -No documentation of training in MH/DD/SAS to meet the needs of the clients.</p> <p>Interview on 04/05/18 staff #2 stated: -He did not remember the trainer/instructor.</p>	V 108	<p>V108</p> <p>Measures in place to correct the deficiency:</p> <p>1.Revised the New Horizon G/H Orientation Checklist to include a "warning" statement reading that no new staff person can be scheduled on a shift until pertinent training has been completed i.e., medication administration, NCI, documentation, etc. See example attached</p> <p>2..Revised the New Horizon G/H Orientation Checklist to include staff training on the MH/DD/SAS needs of the consumer(s). Example attached Attachment #1</p> <p>2.Clinical Director/LPC will train the present staff with examples of various MH/DD/SAS diagnosis and how to address most appropriately/effectively utilizing the best practice methods in order to be equipped to meet the needs of the consumers.</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.Clinical Director/LPC will be responsible for continuous training with the staff as new consumers are admitted to the group home and as diagnosis needs are modified.</p> <p>2.Clinical Director/LPC will provide shadowing of the direct care staff and document discussion of the shadowing during formal supervision.</p> <p>3.Updated copies of the Orientation Checklist relevant to any staff person in the Probationary time period will be forwarded to the CEO/owner prior to hire, at the end of the first week, at the end of the first month and each subsequent</p>	<p>4-29-18</p> <p>4-29-18</p> <p>5-12-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

			V108 continued month during the first 90 days of new hire. Who is monitoring and how often to ensure the problem will not re-occur: Owner/CEO and Quality Management Director will monitor the ongoing training, shadowing, and supervision documentation by review of personnel record documentation at least 10% of personnel records per month and the review of updated Orientation Checklist forms during a new hire's first 90 days of hire.	Ongoing
--	--	--	---	---------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 2</p> <ul style="list-style-type: none"> - He did not have training in MH/DD/SAS to meet the needs of the clients. <p>Review on 04/10/18 of Staff #6's personnel file revealed:</p> <ul style="list-style-type: none"> -Date of application on 02/17/18. -No documentation of training in MH/DD/SAS to meet the needs of the clients. <p>Interview on 04/12/18 staff #6 stated:</p> <ul style="list-style-type: none"> - She had received no training at the facility; <p>"[Staff #4] helped us and showed us videos, we were in a garage in [Licensee]'s other level III group home in [nearby county]."</p> <ul style="list-style-type: none"> -She had no training in MH/DD/SAS to meet the needs of the clients. <p>Review on 04/10/18 of Staff #9's personnel file revealed:</p> <ul style="list-style-type: none"> -Date of application on 02/02/18. -No documentation of training in MH/DD/SAS to meet the needs of the clients. <p>Interview on 04/09/18 staff #9 stated:</p> <ul style="list-style-type: none"> -He had no training on MH/DD/SAS to meet the needs of the clients. -He had received no training at the facility. "All of my training was on the job training..." <p>Review on 04/10/18 of Staff #10's personnel file revealed:</p> <ul style="list-style-type: none"> -Date of application on 02/13/18. -No documentation of training in MH/DD/SAS to meet the needs of the clients. <p>Interview on 04/10/18 staff #10 stated:</p> <ul style="list-style-type: none"> -He worked his first day at the facility before he turned in his application. - He had received "no training at all." -He had no training in MH/DD/SAS to meet the 	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	Continued From page 3 needs of the clients. Review on 04/10/18 of the Operations Manager/Group Home Manager's personnel file revealed: -Date of application on 02/20/18. -No documentation of training in MH/DD/SAS to meet the needs of the clients. Interview on 04/05/18 the Operation Manager/Group home manager stated: -He had only worked for one week at the facility. - He was not sure he had received training specific to the MH/DD/SAS to meet the needs of the clients. Interview on 04/10/18 the Licensee stated: -She had paid to have the trainings completed for staff. -She thought all staff had trainings completed. No contact information or verification from the Licensee and/or the trainer was received by the completion of the survey process on 04/13/18. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 4</p> <p>of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment for 5 of 5 audited clients (#2, #3, #4, #6, #7). The findings are:</p> <p>Review on 04/09/18 of client #2's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 02/27/18. - Diagnoses of Major Depression Disorder, Psychosis Disorder, Schizophrenia and Attention Deficit Hyperactivity Disorder (ADHD). - Person Centered Plan (PCP) updated on 01/26/18 revealed, Local DSS (Department of Social Services) custody, history of out of home 	V 112	<p>V112</p> <p>Measures in place to correct the deficiency:</p> <p>1. Training Director will train the staff on the correlation from the needs reflected on the clinical assessment, goals and strategies reflected on the treatment plan, and the service provided evidenced by the service note documentation.</p> <p>2. Clinical Director/LPC will train the staff on how to recognize new consumer behaviors and how to address.</p> <p>3. Quality Management Director will train the staff on utilizing the Group Home Daily Schedule specifically stressing the educational time vs excessive TV watching. See attached copy of Daily Schedule</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1. Clinical Director/LPC will review all clinical assessments and treatment plans to ensure the needs evidenced on the assessment are clearly addressed in the treatment plan goals and strategies.</p> <p>2. Clinical Director/LPC and Quality Management Director will review medical record documentation weekly to ensure the service notes are clearly reflecting services that address the needs of the consumer per treatment plan and clinical assessment. Results of the review will be addressed in staff meetings and individual supervisions if needed.</p> <p>3. Clinical Director/LPC will "shadow" the group home staff to ensure the services are</p>	<p>5-12-18</p> <p>5-12-18</p> <p>5-12-18</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

			<p>V112 continued</p> <p>being provided according to DMH Rules. Results of the review will be addressed in staff meetings and individual supervisions if needed.</p> <p>4. Clinical Director and Quality Management Director will complete “surprise” visits to the group home on various shifts to ensure the group home activity schedule are being followed. Results of the review will be addressed in staff meetings and individual supervisions if needed.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur:</p> <p>Clinical Director, Quality Management Director and CEO/Owner</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Daily and ongoing</p>
--	--	--	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 5</p> <p>placements, "treatment of his aggression and psychosis...history of responding to internal stimuli...becomes easily irritated by redirection...observed in both states of euphoria and withdrawn/depression...group home staff will facilitate structured activities and utilize behavior management system and regular verbal and written feedback to help resident better manage behaviors...therapist will engage resident in individual therapy in order to explore triggers for anger and other strong feelings and teach skills for more effectively managing anger, aggression and other impulsive behaviors. Therapist will facilitate group with resident and peers in order to increase positive communication and problem solving skills..."</p> <p>No implementation of strategies to address any of the above referenced behaviors and issues as noted in the treatment plan.</p> <p>Review on 04/05/18 of client #3's record revealed:</p> <ul style="list-style-type: none"> - 9 year old male. - Admission date of 03/17/18. - Diagnoses of Bipolar Disorder, Posttraumatic Stress Disorder (PTSD), ADHD, DisruptiveMood Disorder, Encopresis and Rule Out Conduct Disorder. - Person Centered Plan (PCP) dated 04/26/17 revealed, "What's not working section; "Nothing is working, he continues to be aggressive and non-compliant. He is stealing food, his aggressive behaviors, mood swings, defiant-won't follow directions and rules and sexual behaviors/gestures, need constant supervision, medications not working, and he is not sleeping." "He bullies other peers...mother reported that [client #3] has pushed and hit her...mother expressed major concern about 	V 112		

Division of Health Service Regulation

VACANT PAGE DUE TO
CONVERTING TO WORD
DOCUMENT

Division of Health Service Regulation

VACANT PAGE DUE TO
CONVERTING TO WORD
DOCUMENT

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE <div style="background-color: black; height: 15px; width: 100%;"></div> LUMBER BRIDGE, NC 28357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 6</p> <p>[client #3] touching his sister inappropriately. Mom reported that [client #3] stuck an object up his sister's butt. Mom and [client #3] reported that [client #3]'s father used to touch him inappropriately. [Client #3] stated he did that to his sister so she can feel how he feels...mom feels for the girls safety. Mom reports that [client #3] has choked her and his younger sister on more than one occasion...he often has major temper tantrums...he screams, yells, slam doors and hits others...[client #3] was involuntary committed on 12/11/17 after a physical altercation with the school staff. As a result of his aggressive behaviors he has pending charges with Dept. (department) of Juvenile Justice for disorderly conduct and assault on a government official...it was reported he is aggressive with staff at the hospital...[client #3] was released from the hospital after 30 days...continues to be aggressive toward others...group home staff will support with use of CBT (cognitive behavioral therapy)...educate [client #3] and family on relapse prevention...teach techniques such as progressive relaxation, self-hypnosis, or biofeedback...teach behavioral alternatives...design a token economy...develop a contingency contract to improve [client #3]'s social skills...use a feeling chart..."</p> <p>- Medical Physician note dated 04/06/18, Assessment: needs higher level of care such as PTRF (PRTF Psychiatric Residential Treatment Facility).</p> <p>Review on 04/09/18 of staff notes revealed:</p> <ul style="list-style-type: none"> -3/20/18 - put in time out room. - 3/20/18 - put in isolation environment. -3/24/18 - put in time out room. -04/03/18 sent to time out room. -04/04/18- found blade and cut himself. 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 7</p> <p>No implementation of strategies to address any of the above referenced behaviors and issues as noted in the treatment plan.</p> <p>Review on 04/09/18 of client #4's record revealed:</p> <ul style="list-style-type: none"> - 16 year old male. - Admission date of 03/07/18. - Diagnoses of Oppositional Defiant Disorder (ODD), PTSD, ADHD, Anxiety /Anger Issues, Conduct Disorder and Cannabis Use Disorder, Mild. - Person Centered Plan (PCP) dated 02/19/18 revealed, history of vandalism to mother's car, "beat car with a sledge hammer," "stole guns from neighbors- found with multiple guns by law enforcement, broke into elderly resident's homes to steal and vandalized homes, hit his grandparents, and mother, and marijuana use...bullies others, 'let me have what I want, when I want it.' Goal: eliminate use of all substances." -No implementation of strategies to address any of the above referenced behaviors and issues as noted in the treatment plan. <p>Review on 04/09/18 of client #6's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 03/17/18. - Diagnoses of Unspecified Schizophrenia Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate. - PCP dated 08/03/17 revealed, "He threatens to hurt mom's dog that she uses as a service dog 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 8</p> <p>and other family pets...history of twisting mom's arm...He needs constant supervision...lack of remorse, his behaviors scare her (mom). He stole his father's truck and wrecked it...impulsiveness...does not see the danger...cruelty to people or animals, often bullies, threatens intimidates others, frequent lying...collaborate with therapist. Therapist will facilitate group with [client #6] and peers in order to increase positive communication and problem solving skills..."</p> <p>-No implementation of strategies to address any of the above referenced behaviors and issues as noted in the treatment plan.</p> <p>Review on 04/09/18 of client #7's record revealed:</p> <ul style="list-style-type: none"> - 14 year old male. - Admission date of 03/14/18. - Diagnoses of ADHD, Conduct Disorder, Disruptive Mood Disorder and Cannabis Use Disorder. - Person Centered Plan (PCP) dated 12/14/17 and assessment dated 03/14/18 revealed, " 'loved street life'- gang banging, smoking marijuana, history of IVC (involuntary commitment) due to threats to kill family and others, his family is afraid of him...he can become extremely angry, easily irritated and argumentative and often blames others, he deliberately annoys others and attempts to intimidate them with threats of violence. History of being spiteful and vindictive as well as destruction of property, lying and leaving home without permission...threatened teachers to 'blow their brains out' and has also threatened his mother on several occasions that he was going to kill her. on the acute unit patient has displayed a quick temper, and has threatened to 'beat down' staff if they do not allow him to go home. Patient 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 9</p> <p>has significant DSS (department of social services) and DJJ (department of juvenile justice) involvement." "Group home staff will provide a safe and stable environment for [client #7] provide supervision and structure, utilize behavior management techniques, and create and implement corrective interventions to facilitate [client #7]'s improvement in demonstration of respect, management of anger and effective coping skills. [Client #7] will receive an individualized education based on needs, instruction in core curriculum and independent living skills, social skills, leisure skills, health and wellness training, and vocation skills through recreation activities five times per week...will provide interaction to build competence and stability through evidence based individual therapy...monthly family therapy sessions with guardian..."</p> <p>-No implementation of strategies to address any of the above referenced behaviors and issues as noted in the treatment plan.</p> <p>During interview on 04/05/18 client #2 stated:</p> <ul style="list-style-type: none"> - No therapist at the facility. - No assigned therapist for treatment needs. <p>During interview on 04/05/18 client #3 stated:</p> <ul style="list-style-type: none"> - He had an incident of smearing feces while placed in the time out room. - No therapist at the facility. - No assigned therapist for treatment needs. - The clients are not allowed to go outside for recreation, just watch TV everyday. <p>During interview on 04/05/18 client #4 stated:</p> <ul style="list-style-type: none"> - No therapist or Substance abuse counselor at the facility for treatment needs. -The clients are not allowed to go outside for recreation, just watch TV everyday. 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 10</p> <p>During interview on 04/05/18 client #6 stated: - No therapist at the facility. - No assigned therapist for treatment needs.</p> <p>During interview on 04/05/18 client #7 stated: - No therapist or Substance abuse counselor at the facility for treatment needs. - The clients are not allowed to go outside for recreation, just watch TV everyday.</p> <p>During interview on 04/05/18 staff #9 stated: - No LP (Licensed Professional) or QP (Qualified Professional) to do therapy with the clients; "no one certified at the facility." - Clients watch TV most of the day and can't go outside for recreational activities.</p> <p>During interview on 04/05/18 staff #10 stated: - No therapist for any client at the facility to work on treatment goals/needs, "clients watched Netflix all day or played video games." - A posted schedule of activities are not followed. - No LP or QP to do therapy with the clients.</p> <p>During interview on 04/05/18 the Operations Manager/Group Home Manager stated: - He had worked at the facility for one week. - No therapist/LP or QP on staff at the facility - No teacher on staff at the facility. - No recreation skills or activities for clients until a fence is built at the facility.</p> <p>During interview on 04/05/18 the Licensee stated: - She was in the process of following up on the clients' treatment plans/goals and strategies. - There was no therapist, LP or QP on staff. - They did not have a teacher on staff, she would do it herself, "I try to find a study guide."</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 11	V 112		
V 114	<p>This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.</p> <p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are:</p> <p>Review on 04/05/18 of facility records revealed: - Facility admitted the first client on 02/26/18. - 1st quarter 2018 (January, February, March); no fire drills documented and no disaster drill documented for any shift for review.</p> <p>Interviews on 04/05/18 and 04/13/18 6 of 7 clients stated:</p>	V 114	<p>V114</p> <p>Measures in place to correct the deficiency:</p> <p>1. Developed a standardized agency checklist with instructions relevant to the required timelines of various types of disaster drills, including fire drills, reflected on the New Horizon Group Home Emergency Operations Plan. See example copy of the Disaster Drills timeline checklist</p> <p>2. Quality Management Director will train staff on the above-mentioned checklist, emphasizing the instructions and the timelines.</p> <p>3. Quality Management Director will train staff</p>	<p>Done 4-30-18</p> <p>5-12-18</p>

Division of Health Service Regulation

			<p>V114 continued</p> <p>on the Emergency Operations Plan for the Level 5-12-18 IV group home.</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.Quality Management Director will monitor the receipt of required Disaster and Fire Drill forms forwarded to the Corporate Office to ensure timely completion, completion on each shift, and completed with realistic simulation.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur:</p> <p>Quality Management Director</p>	<p>Ongoing</p> <p>Ongoing</p>
--	--	--	--	-------------------------------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 12 - Clients #4, #7, #1, #2, #3 and #6 stated they had not completed any fire or disaster drills at the facility. Interviews on 04/05/18 through 04/13/18 five staff stated: - Staff #6, #9, #10, #3 and staff #2 stated they had not completed any fire or disaster drills at the facility with the clients. Interview on 04/05/18 the Licensee stated: -She admitted the first client to the facility on 02/26/18. -The shifts at the facility were 1st from 8a to 4p and second 4p to 12midnight and third shift from 12am to 8am and weekends were 12 hour shifts 8am to 8pm and 8pm to 8am on Saturday and Sunday. - She understood the fire and disaster drills were to be completed quarterly and repeated on each shift.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE <div style="background-color: black; height: 15px; width: 100%;"></div> LUMBER BRIDGE, NC 28357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 13</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 6 of 6 audited staff (#2, #3, #6, #9, #10 and the Operations Manager/Group Home Manager) failed to administer medications only by unlicensed persons trained by a registered nurse, pharmacist, or other legally qualified person and privileged to prepare and administer medications and as ordered by the physician and maintain an accurate MAR for 3 of 5 audited clients (#2, #3, #6). The findings are:</p> <p>Review on 4/10/18 of client #2's record revealed: - 17 year old male admitted 02/27/18. - Diagnoses of Major Depression Disorder, Psychosis Disorder, Schizophrenia and Attention Deficit Hyperactivity Disorder (ADHD). - Order dated 04/06/18, Prozac 10 mg (milligrams), 1 tablet daily. (antidepressant).</p>	V 118	<p>V118</p> <p>Measures in place to correct the deficiency: 1. Medication Administration training was completed again with the present staff by a Registered Nurse. See attached training certificates with date, attendees name and the signature of the trainer. See copy of the trainer's credentials.</p> <p>Measures in place to prevent reoccurrence of the problem: 1. The Clinical Director/LPC and CEO/owner will review the MAR's on a daily basis to ensure the documentation is complete and that medications are given as prescribed. Registered Nurse will review when present in the group home to ensure medications are given according to physician orders.</p> <p>2. The Personnel Orientation Checklist was revised to reflect the specific training events related to residential services i.e., medication administration, CPR, 1st Aid, etc. A warning note was added to the checklist that no new hire could be placed on the shift schedule until training events were completed. See attached Orientation Checklist Attachment #1</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC and CEO/owner will review daily. Registered Nurse will review during scheduled visits to the group home.</p>	<p>4-12-18</p> <p>Daily and ongoing</p> <p>4-30-18</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 14</p> <p>Review on 4/10/18 of client #2's April 2018 MAR revealed no documentation Prozac was administered from 04/06/18 - 04/10/18.</p> <p>Review on 04/10/18 of client #2's medication label revealed medication was filled on 04/06/18.</p> <p>Review on 04/10/18 of client #3's record revealed:</p> <ul style="list-style-type: none"> - 9 year old male. - Admission date of 03/17/18. - Diagnoses of Bipolar Disorder, Posttraumatic Stress Disorder (PTSD), ADHD, Disruptive Mood Disorder, Encopresis and Rule Out Conduct Disorder. - Order dated 04/06/18, Amantadine 100 mg, 1 tablet daily (treats dyskinesia, sudden uncontrolled movements). <p>Review on 4/10/18 of client #3's April 2018 MAR revealed no documentation Amantadine was administered from 04/06/18 - 04/10/18.</p> <p>Review on 04/10/18 of client #3's medication label revealed medication was filled on 04/06/18.</p> <p>Review on 04/09/18 of client #6's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 03/17/18. - Diagnoses of Unspecified Schizophrenia Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate. - Order dated 04/06/18, Amantadine 100 mg, 1 tablet daily (treats dyskinesia, sudden uncontrolled movements). 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 15</p> <p>Review on 4/10/18 of client #6's April 2018 MAR revealed no documentation Amantadine was administered from 04/06/18 - 04/10/18.</p> <p>Review on 04/10/18 of client #6's medication label revealed medication was filled on 04/06/18.</p> <p>Review on 04/10/18 of the clients' MARS revealed: -Staff #6, #2, #3, #12 and #8 signed/initialed the clients' MARS to reflect they administered medications to the clients at the facility.</p> <p>Review on 04/10/18 of Staff #2's personnel file revealed: -Date of application on 02/20/18. -Documentation of Medication Administration certificate contained a hand written and outline of a copied and pasted date of February 22, 2018 through renewal date of February 28, 2019 and no signature by the trainer. Interview on 04/05/18 staff #2 stated: -He administered medications on his shift. -He did not remember the trainer/instructor. - He did not have training in MH/DD/SAS to meet the needs of the clients.</p> <p>Review on 04/10/18 of Staff #3's personnel file revealed: -Date of application on 02/20/18. -Documentation of Medication Administration certificate contained a hand written and outline of a copied and pasted date of February 22, 2018 through renewal date of February 28, 2019 and no signature by the trainer.</p> <p>Review on 04/10/18 of Staff #6's personnel file revealed: -Date of application on 02/17/18.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE <div style="background-color: black; height: 15px; width: 100%;"></div> LUMBER BRIDGE, NC 28357			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 118	<p>Continued From page 16</p> <p>-Documentation of Medication Administration certificate contained a hand written and outline of a copied and pasted date of February 22, 2018 through renewal date of February 28, 2019 and no signature by the trainer.</p> <p>Review on 04/10/18 of Staff #9's personnel file revealed: -Date of application on 02/02/18. -Documentation of Medication Administration certificate contained a hand written and outline of a copied and pasted date of February 22, 2018 through renewal date of February 28, 2019 and no signature by the trainer.</p> <p>Review on 04/10/18 of Staff #10's personnel file revealed: -Date of application on 02/13/18. -Documentation of Medication Administration certificate contained a hand written and outline of a copied and pasted date of February 22, 2018 through renewal date of February 28, 2019 and no signature by the trainer.</p> <p>Review on 04/10/18 of the Operations Manager/Group Home Manager's personnel file revealed: -Date of application on 02/20/18. -Documentation of Medication Administration certificate contained a hand written and outline of a copied and pasted date of February 22, 2018 through renewal date of February 28, 2019 and no signature by the trainer</p> <p>Interview on 04/05/18 staff #2 stated: -He administered medications to the clients. - He could not recall who the trainer for medication administration.</p> <p>Interview on 04/05/18 staff #3 stated:</p>	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 17</p> <p>-She did not remember the trainer/instructor for medication administration.</p> <p>-She "sometimes" administered medications to the clients.</p> <p>Interview on 04/12/18 staff #6 stated:</p> <ul style="list-style-type: none"> - She had not received medication administration training. - She had received no medication administration training by a nurse. - "[Staff #4] helped us and showed us videos, we were in a garage in [Licensee]'s other level III group home in [nearby county]." <p>Interview on 04/09/18 staff #9 stated:</p> <ul style="list-style-type: none"> -He administered the clients' medications. - He had not received medication administration training. - "All of my training was on the job training, no medication training." <p>Interview on 04/10/18 staff #10 stated:</p> <ul style="list-style-type: none"> -He worked his first day at the facility before he turned in his application. -He administered the clients' medications. - He had not received medication administration training. - He had received "no training at all." - Staff "[#1] showed me how to do meds (medications); she wanted to throw away meds and have me sign off; I said I'm not doing that." <p>Interview on 04/05/18 the Operation Manager/Group home manager stated:</p> <ul style="list-style-type: none"> -He had only worked for one week at the facility. - He was not sure who the trainers were for any of the trainings. <p>Interview on 04/10/18 the Licensee stated:</p> <ul style="list-style-type: none"> -The staff had not picked up the medications until 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 18 4/10/18 for the clients. - The pharmacy had not called the facility to inform them the prescriptions were ready. - She had paid to have the trainings completed for staff. - She had noticed the dates on the training certificates looked as if the date had been cut and pasted on the certificate and copied and maybe the trainer had copied multiple certificates that way. - She would contact the trainer and have the trainer contact DHSR (Division of Health Service Regulation). - She thought all staff had trainings completed. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 131	<p>Continued From page 19</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hire affecting 4 of 6 audited staff (#2, #3, #6 and the Operations Manager/Group Home Manager). The findings are:</p> <p>Review on 04/10/18 of Staff #2's personnel file revealed: -Date of application on 02/20/18. -Job title of residential staff. -No documentation the HCPR had been accessed.</p> <p>Review on 04/10/18 of Staff #3's personnel file revealed: -Date of application on 02/20/18. -Job title of residential staff. -No documentation the HCPR had been accessed.</p> <p>Review on 04/10/18 of Staff #6's personnel file revealed: -Date of application on 02/17/18. -Job title of residential staff. -No documentation the HCPR had been accessed.</p> <p>Review on 04/10/18 of the Operations Manager/Group Home Manager's personnel file revealed: -Date of application on 02/20/18. - Job title of Operations Manager/Group Home Manager. -No documentation the HCPR had been accessed.</p>	V 131	<p>V131</p> <p>Measures in place to correct the deficiency: 1. Quality Management Director will review the Personnel Orientation Checklist with the Group Home Manager and Group Home Administrative Staff emphasizing the requirements that must be completed prior to hire, including the Health Care Registry Check. See copy of the revised Personnel Orientation Checklist with warning statement.</p> <p>Measures in place to prevent reoccurrence of the problem: 1. Updated copies of the Personnel Orientation Checklist will be forwarded to the CEO/Owner prior to hire to reflect all "prior to hire" requirements have been completed. No potential staff person can be offered a job without approval from the CEO. See copy of the attached Personnel Orientation Checklist</p> <p>2. Quality Management Director will complete personnel record reviews to ensure all prior to hire paperwork documents are obtained within the correct timelines.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO/owner will review personnel documentation prior to job offer.</p> <p>Quality Management Director will review all personnel records at least monthly.</p>	<p>5-12-18 and ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

VACANT PAGE DUE TO CONVERTING
TO WORD DOCUMENT

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 131	Continued From page 20 Interview on 04/10/18 the Licensee stated: -She believed the HCPR had been accessed on all staff. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.	V 131		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort	V 132		

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

			<p>V132 continued</p> <p>and individual personnel supervisions if warranted.</p> <p>2. Clinical Director/LPC will provide daily shadowing and supervision.</p> <p>3. Independent Compliance Consultant will monitor the reporting system and alert CEO/Owner and additional persons to begin any needed reporting processes and implement in-house internal investigation, if warranted.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Quality Management Director Clinical Director/LPC Independent Compliance Consultant</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
--	--	--	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 22 -No internal investigations were conducted on above referenced incidents. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1.	V 132		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 23 Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	<p>Continued From page 24</p> <p>records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <ol style="list-style-type: none"> (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal 	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 25 history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE LUMBER BRIDGE, NC 28357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	<p>Continued From page 26</p> <p>Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, within five business days of making the conditional offer of employment, the facility failed to request a criminal background check for 6 of 6 audited staff (#2, #3, #6, #9, #10, and the Operations Manager/Group Home Manager). The findings</p>	V 133	<p>V133 Measures in place to correct the deficiency:</p> <p>1. New Horizon Group Home Personnel Orientation Checklist has been revised to reflecting the criminal background must be completed prior to the offer of hire. The checklist has also been revised to include a note stating no offers of hire can be given without the approval of the CEO. See attached Personnel Orientation Checklist</p> <p>2. Quality Management Director will train the Group Home Manager and all Administrative staff responsible for completion of the criminal background checks with using the Personnel Orientation Checklist and New Horizon Policy P-1 related to Personnel. See Personnel Policy</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1. Updated copies of the Personnel Orientation Checklist will be forwarded to the CEO/Owner prior to hire offer. No hiring of potential staff can be completed without the approval of the CEO/Owner ensuring all prior to hire documents are in place.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur:</p> <p>CEO/Owner</p>	<p>4-30-18</p> <p>No later than 5-12-18</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	<p>Continued From page 27</p> <p>Review on 04/10/18 of Staff #2's personnel file revealed: -Date of application on 02/20/18. -Job title of residential staff. -No documentation the criminal background check had been requested.</p> <p>Review on 04/10/18 of Staff #3's personnel file revealed: -Date of application on 02/20/18. -Job title of residential staff. -No documentation the criminal background check had been requested.</p> <p>Review on 04/10/18 of Staff #6's personnel file revealed: -Date of application on 02/17/18. -Job title of residential staff. -No documentation the criminal background check had been requested.</p> <p>Review on 04/10/18 of Staff #9's personnel file revealed: -Date of application on 02/02/18. -Job title of residential staff. -No documentation the criminal background check had been requested..</p> <p>Review on 04/10/18 of Staff #10's personnel file revealed: -Date of application on 02/13/18. -Job title of residential staff. -No documentation the criminal background check had been requested.</p> <p>Review on 04/10/18 of the Operations Manager/Group Home Manager's personnel file revealed:</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 28 -Date of application on 02/20/18. - Job title of Operations Manager/Group Home Manager. -No documentation the criminal background check had been requested. Interview on 04/10/18 the Licensee stated: -The staff should have all had criminal background checks requested. - She did not know why the staff at her office had not requested criminal background checks for all the staff. -She saw in the personnel record book all the consents to request the criminal background checks for the staff. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.	V 133		
V 301	27G .1801 Intensive Res. Tx. Child/Adol - Scope 10A NCAC 27G .1801 SCOPE (a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility. (b) It shall not be the primary residence of an individual who is not a client of the facility. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or	V 301		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	<p>Continued From page 29</p> <p>adolescents shall not meet criteria for acute inpatient psychiatric services.</p> <p>(d) The children or adolescents served shall require the following:</p> <p>(1) removal from home to an intensive integrated treatment setting; and</p> <p>(2) treatment in a locked setting.</p> <p>(e) Services shall be designed to:</p> <p>(1) assist in the development of symptom and behavior management skills;</p> <p>(2) include intensive, frequent and pre-planned crisis management;</p> <p>(3) provide containment and safety from potentially harmful or destructive behaviors;</p> <p>(4) promote involvement in regular productive activity, such as school or work; and</p> <p>(5) support the child or adolescent in gaining the skills needed for reintegration into community living.</p> <p>(f) The intensive residential treatment facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to meet the scope of the license for an intensive residential treatment facility identified to provide intensive treatment and supervision in the residential setting affecting 5 of 5 audited clients (#2, #3, #4, #6, #7). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108). Based</p>	V 301	<p>V301 For each of the below cross reference deficiencies involved with the failure to meet the scope of the license, see each of the individual cross referenced notes that reiterate the plans reflected in the previous deficient sections related to the cross reference tag.</p> <p>V108 Corrective measures: revision of the Personnel Orientation Checklist with more in-depth directional requirements, Clinical Director/LPC provide shadowing and individual training and training by the Clinical Director/LPC on various mental health diagnosis that would be evident in the group home population.</p> <p>System(s) in place to ensure non-re-occurrence: Continued monitoring by the CEO/Owner during the new hire process and probationary period relevant to documents being in place prior to hire and required training.</p> <p>Monitoring: Continued monitoring of personnel records by the Quality Management Director. See the Agency Personnel Record Audit Sheet</p> <p>V112 Measures in place to correct the deficiency: Training Director will train staff on medical</p>	<p>4-29-18</p> <p>5-12-18</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

			<p>V301 (V112) continued</p> <p>record documentation and the correlation between consumer needs from the clinical assessment, treatment plan goals/strategies, and service provided reflected on the service notes; Clinical Director will train staff recognizing new behaviors and how to address. QM Director will train the staff how to utilize the Group Home Daily Schedule.</p> <p>Measures in place to prevent reoccurrence of the problem: Clinical Director will review all clinical assessments and treatment plans, upon completion to ensure the needs reflected on the assessment are addressed appropriately in the treatment plan; Clinical Director will review the assessment and treatment plan with the staff prior to the implementation; Clinical Director and QM Director will review medical record documentation weekly to ensure the service notes are clearly reflecting services that address the consumer's needs; Clinical Director will shadow the group home staff to ensure services are being provided according to DMH Rules; unannounced visits will be completed at various shifts to ensure the group home Daily Schedule is being implemented.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director, Quality Management Director and CEO/Owner</p>	<p>5-12-18</p> <p>Ongoing</p> <p>Ongoing</p>
--	--	--	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	<p>Continued From page 30</p> <p>on record review and interview, the facility failed to ensure staff were trained for MH/DD/SAS (Mental Health/Developmental Disabilities/Substance Abuse Services) needs of the clients for 6 of 6 audited staff (#2, #3, #6, #9, #10 and the Operations Manager/Group Home Staff).</p> <p>Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (Tag V112). Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment for 5 of 5 audited clients (#2, #3, #4, #6, #7).</p> <p>Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS(V118). Based on record reviews and interviews, 6 of 6 audited staff (#2, #3, #6, #9, #10 and the Operations Manager/Group Home Manager) failed to administer medications only by unlicensed persons trained by a registered nurse, pharmacist, or other legally qualified person and privileged to prepare and administer medications and as ordered by the physician and maintain an accurate MAR for 3 of 5 audited clients (#2, #3, #6).</p> <p>Cross Reference : G.S. §131E-256 (d2) HEALTH CARE PERSONNEL REGISTRY (V131). Based on record review and interviews, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hiring affecting 4 of 6 audited staff.</p> <p>Cross Reference: G.S. §131E-256 (g) HEALTH CARE PERSONNEL REGISTRY(V132). Based on record reviews and interviews, the facility failed to report allegations of abuse or neglect to</p>	V 301	<p>V118 Measures in place to correct the deficiency: Medication Administration training was completed with the presently employed staff by a RN; Credentials of the trainer were obtained. Measures in place to prevent reoccurrence of the problem: The Clinical Director and CEO/Owner will review the MAR's daily to ensure documentation is complete and according to physician orders; revised Personnel Orientation Checklist to reflect the timeline for completion of Medication Administration training, including a specific note related to the training events and scheduling of staff. Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC and CEO/owner will review daily; Registered Nurse will review during scheduled visits to the group home.</p> <p>V131 Measures in place to correct the deficiency: QM Director will review the Personnel Orientation Checklist with the Group Home Manager and all Administrative Staff that are involved with the completion of the personnel requirements prior to hire. Measures in place to prevent reoccurrence of the problem: Forward copies of the Personnel Orientation Checklist to the CEO/Owner prior to hire to reflect all "prior to hire" documents have been completed; no potential new staff person can be offered a job without the approval of the CEO; QM Director will complete personnel record reviews to ensure all prior to hire paperwork documents are obtained within the specified timelines. Who is monitoring and how often to ensure the problem will not re-occur: CEO/owner</p>	<p>4-12-18</p> <p>Ongoing</p> <p>4-30-18</p> <p>Daily and Ongoing</p> <p>5-12-18 and ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

		<p>V301 (V131) continued will review personnel documentation prior to job offer; Quality Management Director will review all personnel records at least monthly.</p> <p>V132 Measures in place to correct the deficiency: QM Director has provided Client Rights training again to the presently employed staff iterating the section related to abuse, neglect, and exploitation; QM Director will continue to train new hire staff and all staff at least annually; QM Director has provided DMH Incident Report Manual Training, especially the chart reflecting when certain additional notifications/documents are to be completed for specific types of incidents, also training what “constitutes” an incident. QM Director has provided training/review of the New Horizon Standard of Operation related to the Reporting of Incident, emphasizing the timelines if an incident is related to abuse, neglect, and exploitation. An in-house email reporting system will be developed for staff and/or consumer to utilize when suspect to or evidence of abuse, neglect, or exploitation; a Standard of Operation related to the in-house reporting process will be developed and subsequent training for the staff/consumers. The Standard of Operation will also include the steps to complete when completing an internal investigation.</p> <p>Measures in place to prevent reoccurrence of the problem: QM Director will provide continued monitoring of the implementation of the “Standard of Operation for Reporting Incidents” through review of service documentation and notification of incidents; Clinical Director/LPC will provide daily shadowing and supervision; Independent Compliance Consultant will monitor the reporting system and alert CEO/Owner and additional persons to begin any warranted reporting processes and implement an internal investigation, if warranted.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Quality Management Director Clinical Director/LPC Independent Compliance Consultant</p>	<p>Ongoing</p> <p>4-21-18</p> <p>4-21-18</p> <p>4-21-18</p> <p>Prior to 5-12-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
--	--	--	---

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 301	<p>Continued From page 31</p> <p>the Health Care Personnel Registry (HCPR) and to investigate all alleged acts of abuse or neglect.</p> <p>Cross Reference: G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT (V133). Based on record reviews and interviews, within five business days of making the conditional offer of employment, the facility failed to request a criminal background check for 6 of 6 audited staff (#2, #3, #6, #9, #10, and the Operations Manager/Group Home Manager).</p> <p>Cross Reference: 10A NCAC 27G .1802 REQUIREMENTS OF LICENSED PROFESSIONALS (V302). Based on record review and interview the facility failed to have a least one full time licensed professional (LP) providing the required clinical and administrative duties related to client services.</p> <p>Cross Reference: 10A NCAC 27G .1803 REQUIREMENTS OF QUALIFIED PROFESSIONALS (V303). Based on record review and interview the facility failed to have a least one full time qualified professional (QP) providing the required clinical and administrative duties related to client services.</p> <p>Cross Reference: 10A NCAC 27G .1804 MINIMUM STAFFING REQUIREMENTS (V304). Based on interview, observation, and record review the facility failed to ensure the minimum number of staff who were available in the facility to meet the clients' assessed needs.</p> <p>Cross Reference: 10A NCAC 27G .1805 OPERATIONS (V305). Based on interview and record reviews and observations, the facility failed to ensure the educational services were made</p>	V 301	<p>V133</p> <p>Measures in place to correct the deficiency: Revision of the agency Personnel Orientation Checklist reflecting the criminal background must be completed prior to the offer of hire and containing a note stating no offers of hire can be given without the approval of the CEO; New Horizon Group Home Personnel Policy was revised to include statement regarding a criminal background check must be obtained at least five business days prior to making a conditional offer of employment; QM Director will train the Group Home Manager and all Administrative staff responsible for completion of the criminal background checks with using the Personnel Orientation Checklist; and QM Director will train all staff on New Horizon Policy P-1 related to Personnel and hiring practices.</p> <p>Measures in place to prevent reoccurrence of the problem: Updated copies of the Personnel Orientation Checklist will be forwarded to the CEO/Owner prior to hire offer; no hiring of potential staff can be completed without the approval of the CEO/Owner ensuring all prior to hire documents are in place.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO/Owner</p> <p>V302:</p> <p>Measures in place to correct the deficiency: A LPC was employed and left employment prior to the survey date. Since the survey date, a full-time LPC has been employed and very active in the training process during this corrective measure time-period. See attached job description</p> <p>Measures in place to prevent reoccurrence of the problem: CEO will ensure the required personnel are in</p>	<p>4-30-18</p> <p>No later than 5-12-18</p> <p>No later than 5-12-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>4-28-18</p>

Division of Health Service Regulation

		<p>V301 (V302) continued</p> <p>place to carry out the clinical and administrative duties related to consumer services.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO/Owner</p> <p>V303</p> <p>Measures in place to correct the deficiency: A QP was employed and left employment prior to the survey date. Since the survey date, a full-time QP has been hired to carry out the clinical and administrative related to consumer services. See the signed job description.</p> <p>Measures in place to prevent reoccurrence of the problem: CEO will ensure the required personnel are in place to carry out the clinical and administrative duties related to consumer services.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO</p> <p>V304</p> <p>Measures in place to correct the deficiency: 1.The New Horizon Group Home Organizational Chart reflects the correct number of staff for the number of consumers in the group home. Each shift will have (4) direct care staff one of which is a shift leader but is also responsible for direct care duties. 2.The agency Residential Level IV Policy and all job descriptions have been revised to include the correct staffing requirements. 3.QM Director will train all staff on the Residential Level IV Policy See the Residential Level IV Policy, Organizational Chart, and job descriptions as examples.</p> <p>Measures in place to prevent reoccurrence of the problem: CEO will ensure the required personnel are in place to carry out the clinical and administrative duties related to consumer services.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO</p> <p>V305:</p> <p>Measures in place to correct the deficiency: 1.A certified teacher has been contracted to</p>	<p>Ongoing</p> <p>Ongoing</p> <p>4-25-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>5-03-18</p> <p>5-03-18</p> <p>On or before 5-12-18</p> <p>Ongoing</p> <p>Ongoing</p>
--	--	--	--

Division of Health Service Regulation

			<p>V301 (V305) continued</p> <p>provide the educational services to the consumers residing at the group home.</p> <p>2.New Horizon has collaborated with the local educational agency to obtain an approved educational program to utilize in the educational component of the service.</p> <p>See contract with certified teacher.</p> <p>See signed approval letter from Robeson County School System</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>CEO will ensure the required personnel are in place to carry out the clinical and administrative duties related to consumer services.</p> <p>CEO will coordinate with the local educational agency to ensure the educational services are provided to the consumers.</p> <p>Upon admission of a new consumer, the facility teaching staff person will obtain an IEP, schedule an IEP to make any needed revisions to be meet the consumer's educational needs, and review all goals and strategies with the staff.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur:</p> <p>CEO to make certain the educational services are provided</p> <p>Educational staff person will ensure the educational program is the most effective to meet the educational needs of the consumers.</p>	<p>2-02-18</p> <p>4-25-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Upon admission of new consumer and Ongoing</p>
--	--	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS CITY STATE ZIP CODE

LUMBER BRIDGE, NC 28357

Division of Health Service Regulation

Division of Health Service Regulation

<p>V301</p>	<p>Continued From page 33</p> <p>Review on 04/10/18 of the Plan of Protection dated 04/10/18 completed by the Licensee revealed:</p> <p>What immediate action will the facility take to ensure the safety of the consumers in your care? -"Training will be done for medications MAR by a RN (Registered Nurse) trainer by 4/27/18 and 4/28/18. Will continue recruit QP, LPC to be hire on or before 4/30/18. Training will also be conducted for Incident, Internal Investigation, HCPR, 4/28/18 for all staff. The meet min (minimal) staffing requirements, I will recruit and training all new hire staff by 4/28/18. Will contact local education dept. (department) by 4/28/18."</p> <p>Describe your plans to make sure the above happens: -"The QA trainer will do all training for areas mentioned for compliance."</p> <p>The facility is licensed as an 1800 and serving 7 clients ages 9 to 17 during this survey. The facility currently has no professional staff, LP or QP, to provide supervision or coordinate other services for the clients. The direct care staff have reported not to have been trained to meet the needs of the clients including MH/DD/SAS needs, alternatives to restrictive interventions, Physical Restraint and Isolation Time-Out as well as medication administration. The clients' treatment plans do not include strategies to address behaviors of aggression, property destruction, substance use as well as smearing of feces. Clients have diagnoses including Impulse Control Disorder, Bipolar disorder, PTSD, ADHD, Oppositional Defiant Disorder, Encopresis, Intermittent Explosive D/O, Autism, IDD Moderate, Anxiety Anger Issues, Cannabis Use, History of substance use. The facility consistently fails to meet minimum staffing having only 2 staff present to attend to up to 7 clients per shift. Clients are</p> <p>Continued From page 33</p>	<p>V301</p>	<p>V301 (V503) continued</p> <p>continued monitoring of service record documentation to ensure that incidents are responded to appropriately and reported timely.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC QM Director</p> <p>Immediate Action Taken:</p> <p>Measures in place to correct the deficiency: 1. Medication Administration training, including the use of a MAR, was completed by RN. See training certificates 2. Incident Reporting (including agency not utilizing time out as a behavior modification technique), Internal Investigation, HCPR training for all staff was completed. See training certificates 3. Recruited and hired LPC and QP. 4. Recruited through a web-based recruiting site for more experienced staff. All of those persons are being trained as if employees and the selection for new hires will be selected from that group once the agency's license has been re-instated. See various training dates 5. Contacted local education department regarding the educational component that will be utilized at the group home. See copy of the approval letter</p> <p>Measures in place to prevent reoccurrence of the problem: Training events will continue. Will ensure all required staffing positions have been filled and remain filled. Continued monitoring of medical record documentation to ensure incident reporting is being appropriately handled and reporting timelines are met.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO/Owner Clinical Director/LPC QM Director</p>	<p>Ongoing</p> <p>2-22-18 3-07-18 4-15-18</p> <p>4-21-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>4-25-18</p> <p>Ongoing</p> <p>Ongoing</p>
-------------	---	-------------	--	---

Division of Health Service Regulation

V301	<p>Continued From page 34</p> <p>receiving no educational services as required and are inside the facility watching TV in a common area the majority of the day. Clients have diagnoses including Impulse Control Disorder, Bipolar disorder, PTSD, ADHD, Oppositional Defiant Disorder, Encopresis, Intermittent Explosive D/O, Autism, IDD Moderate, Anxiety Anger Issues, Cannabis Use, History of substance use. The facility consistently fails to meet minimum staffing having only 2 staff present to attend to up to 7 clients per shift. Clients are receiving no educational services as required and are inside the facility watching TV in a common area the majority of the day. There are no routine schedule outdoor/recreational times. The licensee reports she was unaware that she was required to coordinate with the Local Education Agency in order to meet the educational needs of the clients. Clients report they only do some worksheets occasionally. No staff are trained in the area of providing educational services and clients have no IEP that would identify their current educational needs as identified by the local education agency. Staff failed to complete documentation of services and incidents. No incident reports have been completed for any of the reported incidences including Isolation Time-Out. This deficiency constitutes a Type A1 rule violation for serious neglect.</p>	V301		
------	--	------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 302	Continued from page 35 27G .1802 Intensive Res. Tx. Child/Adol - Req. of L P 10A NCAC 27G .1802 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Each facility shall have at least one full-time licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance related disorders this shall include a Licensed Clinical Addiction Specialist or a Certified Clinical Supervisor. (b) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its licensed professional(s). At a minimum these policies shall include: (1) supervision of direct care staff; (2) oversight of emergencies; (3) provision of direct clinical psychoeducational services to children, adolescents or families; (4) participation in treatment planning meetings; and (5) coordination of each child or adolescent's treatment plan	V 302		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 302	<p>Continued From page 36</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to have a least one full time licensed professional (LP) providing the required clinical and administrative duties related to client services. The findings are:</p> <p>Review on 04/10/18 of the facility's personnel binder revealed no personnel record for a LP.</p> <p>Interview on 04/09/18 the Licensee stated: -She did not have a LP on staff. -She believed she had completed a personnel record for a LP. - She did not have the dates when a LP worked at the facility. -The LP "just came and left" the position at the facility.</p> <p>This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V30)1 for a Type A1 rule violation.</p>	V 302	<p>V302</p> <p>Measures in place to correct the deficiency: 1. Recruited and hired full-time LPC at the Level IV. See copy of signed job description</p> <p>Measures in place to prevent reoccurrence of the problem: CEO will ensure LPC position is filled. If a vacancy becomes apparent, CEO will immediately and vigorously recruit to fill the position.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO</p>	<p>4-28-18</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 303	<p>Continued from page 37</p> <p>27G .1803 Intensive Res. Tx. Child/Adol - Req. of Q P</p> <p>10A NCAC 27G .1803 REQUIREMENTS OF QUALIFIED PROFESSIONALS</p> <p>Each facility shall have at least one full-time qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, the qualified professional shall have two years of direct client care experience.</p> <p>For each facility:</p> <ul style="list-style-type: none"> a qualified professional shall perform clinical and administrative responsibilities a minimum of 40 hours each week; and 75% shall occur when children or adolescents are awake and present in the facility. <p>(c) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include:</p> <ul style="list-style-type: none"> management of the day to day operations of the facility; supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; participation in treatment planning meetings; and provision of basic case management functions. 	V 303		

Division of Health Service Regulation

<p>V 303</p>	<p>Continued From page 38</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to have a least one full time qualified professional (QP) providing the required clinical and administrative duties related to client services. The findings are:</p> <p>Review on 04/10/18 of the facility's personnel binder revealed no personnel record for a QP.</p> <p>Interview on 04/09/18 the Licensee stated: -She did not have a QP on staff. -She believed she had completed a personnel record for a QP. - She did not have the dates when the QP worked at the facility. -The QP had "just quit" her position at the facility.</p> <p>This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.</p>	<p>V 303</p>	<p>Measures in place to correct the deficiency: 1. Recruited and hired QP position. The QP that was previously employed as QP at the Level IV⁴⁻²⁵⁻¹⁸ returned to the position approximately three weeks after leaving. All new personnel documents were completed for the re-hire.</p> <p>Measures in place to prevent reoccurrence of the problem: CEO will ensure LPC position is filled. If a vacancy becomes apparent, CEO will immediately and vigorously recruit to fill the position.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: CEO</p>	<p>Ongoing</p> <p>Ongoing</p>
--------------	---	--------------	--	-------------------------------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE LUMBER BRIDGE, NC 28357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 304	<p>Continued From page 39</p> <p>27G .1804 Intensive Res. Tx. Child/Adol - Min staffing</p> <p>10A NCAC 27G .1804 MINIMUM STAFFING REQUIREMENTS</p> <p>(a) A Qualified Professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.</p> <p>(b) If children or adolescents are cared for in separate units/buildings, the minimum staffing numbers shall apply to each unit/building.</p> <p>(c) The minimum number of direct care staff required when children or adolescents are present and awake is as follows:</p> <p>(1) three direct care staff shall be present for up to six children or adolescents;</p> <p>(2) four direct care staff shall be present for seven, eight or nine children or adolescents; and</p> <p>(3) five direct care staff shall be present for 10, 11 or 12 children or adolescents.</p> <p>(d) During child or adolescent sleep hours three direct care staff shall be present of which two shall be awake and the third may be asleep.</p> <p>In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(d) of this Rule, more direct care staff may be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to meet the minimum staffing requirements. The findings are:</p> <p>Review on 04/09/18 of client #2's record revealed: - 17 year old male.</p>	V 304	<p>V304</p> <p>Measures in place to correct the deficiency:</p> <p>1. Revised the staff job descriptions with the correct staffing ratios. 4-20-18 and 5-03-18</p> <p>2. Recruited qualified staff on a web-based site. The training process of these potential staff is presently being completed. The actual offer of hire will be completed once the agency license is re-instated. Ongoing</p> <p>3. Revised New Horizon Residential Level IV Policy with the correct staffing ratios. 5-03-18</p> <p>4. QP will train the staff on the revised Policy. Prior to 5-12-18</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1. Clinical Director/LPC, QP, and Quality Management Director will monitor to ensure the correct staffing ratio is met. Ongoing</p> <p>2. CEO will ensure LPC position is filled. If a vacancy becomes apparent, CEO will immediately and vigorously recruit to fill the position. Ongoing</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC; CEO/Owner; Qualified Professional; and Quality Management Director Ongoing</p>	

Division of Health Service Regulation

<p>V 304</p>	<p>Continued from page 40</p> <ul style="list-style-type: none"> - Admission date of 02/27/18. - Diagnoses of Major Depression Disorder, Psychosis Disorder, Schizophrenia and Attention Deficit Hyperactivity Disorder (ADHD). - Person Centered Plan (PCP) updated on 01/26/18 revealed, "treatment of his aggression and psychosis..history of responding to internal stimuli...becomes easily irritated by redirection...observed in both states of euphoria and withdrawn/depression..... staff will facilitate structured activities and utilize behavior management system and regular verbal and written feedback to help resident better manage behaviors...group home staff will provide monitoring 24 hours per 7 days." 	<p>V 304</p>		
--------------	--	--------------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 304	<p>Continued From page 41</p> <p>Review on 04/05/18 of client #3's record revealed:</p> <ul style="list-style-type: none"> - 9 year old male. - Admission date of 03/17/18. - Diagnoses of Bipolar Disorder, Posttraumatic Stress Disorder (PTSD), ADHD, Disruptive Mood Disorder, Encopresis and Rule Out Conduct Disorder. <p>Person Centered Plan (PCP) dated 04/26/17 revealed, "What's not working section; "Nothing is working, he continues to be aggressive and non-compliant. He is stealing food, his aggressive behaviors, mood swings, defiant-won't follow directions and rules and sexual behaviors/gestures, need constant supervision, medications not working, and he is not sleeping." "He bullies other peers...mother reported that [client #3] has pushed and hit her...mother expressed major concern about [client #3] touching his sister inappropriately. Mom reported that [client #3] stuck an object up his sister's butt. Mom and [client #3] reported that [client #3]'s father used to touch him inappropriately...he often has major temper tantrums...he screams, yells, slam doos and hits others...continues to be aggressive toward others...group home staff will support with use of CBT (cognitive behavioral therapy)...educate [client #3] and family on relapse prevention..teach techniques such as progressive relaxation, self-hypnoses, or biofeedback, ...teach behavioral alternatives...design a token economy...develop a contingency contract to improve [client #3]'s social skills...use a feeling chart..."</p> <ul style="list-style-type: none"> - Medical Physician note dated 04/06/18, Assessment: needs higher level of care such as 	V 304		

Division of Health Service Regulation

<p>V 304</p>	<p>Continued From page 42</p> <p>PTRF (PRTF) (Psychiatric Residential Treatment Facility).</p> <p>-Review on 04/05/18 of staff notes revealed:</p> <p>- "3/20/18 - put in time out room.</p> <p>- 3/20/18 - put in isolation environment.</p> <p>- 3/24/18 - put in time out room,.</p> <p>- 04/03/18- sent to time out room.</p> <p>- 04/04/18- found blade and cut himself."</p> <p>- PCP dated 02/10/18 revealed need for "constant supervision."</p> <p>Review on 04/09/18 of client #4's record revealed:</p> <p>- 16 year old male.</p> <p>- Admission date of 03/07/18.</p> <p>Diagnoses of Oppositional Defiant Disorder (ODD), PTSD, ADHD, Anxiety /Anger Issues, Conduct Disorder and Cannabis Use Disorder, Mild.</p> <p>- Person Centered Plan (PCP) dated 02/19/18 revealed, history of vandalism...stole guns from neighbors, found with multiple guns by law enforcement, broke into elderly resident's homes to steal and vandalized homes, hit his grandparents, and mother and marijuana use...bullies others, 'let me have what I want, when I want it.' Goal: eliminate use of all substances.</p> <p>Staff will provide monitoring "24 hours per day, 7 days per week."</p> <p>Review on 04/09/18 of client #6's record revealed:</p> <p>- 17 year old male.</p> <p>- Admission date of 03/17/18.</p> <p>- Diagnoses of Unspecified Schizophrenia Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate.</p> <p>- PCP dated 08/03/17 revealed, "He threatens to hurt mom's dog that she uses as a service dog and other family pets...history of twisting mom's arm...He needs constant supervision...lack of remorse...impulsiveness...does not see the</p>	<p>V 304</p>		
--------------	--	--------------	--	--

Division of Health Service Regulation

V 304	<p>Continued From page 43</p> <p>- danger...cruelty to people or animals, often bullies, threatens intimidates others, frequent lying...collaborate with therapist...his recent behaviors requires a locked setting...level IV residential treatment, 24 hours a day, 7 days a week..."</p> <p>Review on 04/09/18 of client #7's record revealed:</p> <ul style="list-style-type: none"> - 14 year old male. - Admission date of 03/14/18. <p>Diagnoses of ADHD, Conduct Disorder, Disruptive Mood Disorder and Cannabis Use Disorder.</p> <p>- Person Centered Plan (PCP) dated 12/14/17 and assessment dated 03/14/18 revealed, " 'loved street life'- gang banging, smoking marijuana, history of IVC due to threats to kill family and others, his family is afraid of him...he can become extremely angry, easily irritated and argumentative and often blames others, he deliberately annoys others and attempts to intimidate them with threats of violence. history of being spiteful and vindictive as well as destruction of property, lying and leaving home without permission...threatened teachers to 'blow their brains out' and has also threatened his mother on several occasions that he was going to kill her...has threatened to 'beat down' staff if they do not allow him to go home. Group home staff will provide a safe and stable environment for [client #7] provide supervision and structure, utilize behavior management techniques, and create and implement corrective interventions to facilitate [client #7]'s improvement in demonstration of respect, management of anger and effective coping skills...independent living skills, social skills, leisure skills, health and wellness training, and vocation skills through recreation activities five times per week...his behaviors require structure at all times...staff will provide monitoring 24 hours per day."</p>	V 304		
-------	--	-------	--	--

Division of Health Service Regulation

V 304	<p>Continued From page 44</p> <p>Observation on 04/05/18 of the facility revealed:</p> <ul style="list-style-type: none"> - 10:00am - 3 staff present with 7 clients at the facility. - Client #2 paced back and forth in the facility. <p>Observation on 04/09/18 of the facility revealed:</p> <ul style="list-style-type: none"> - 11:09am - 3 staff present with 6 clients at the facility. - Client #2 paced back and forth in the facility. <p>Observation on 04/10/18 of the facility revealed:</p> <ul style="list-style-type: none"> - 6:00pm - 2 staff present with 6 clients at the facility. - Client #2 actively paced back and forth in the facility. <p>During interview on 04/05/18 client #2 stated:</p> <ul style="list-style-type: none"> -He was not sure how many staff were on each shift at the facility. <p>During interview on 04/05/18 client #3 stated:</p> <ul style="list-style-type: none"> -He was not sure how many staff were on each shift at the facility. <p>During interview on 04/05/18 client #4 stated:</p> <ul style="list-style-type: none"> - Sometimes 3 or 4 staff were at the facility. <p>During interview on 04/05/18 client #6 stated:</p> <ul style="list-style-type: none"> -He was not sure how many staff were on each shift at the facility. <p>During interview on 04/05/18 client #7 stated:</p> <ul style="list-style-type: none"> - "Mostly two staff" were on each shift at the facility. 	V 304		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 304	<p>Continued From page 45</p> <p>Interview on 04/12/18 staff #6 stated: - There were two staff on each shift.</p> <p>Interview on 04/09/18 staff #9 stated: -"Mostly two staff work on each shift."</p> <p>Interview on 04/09/18 staff #10 stated: -There were "supposed to be 3 or 4 staff" on each shift. -He sometimes worked alone on his shift. - There were two staff sometimes on each shift.</p> <p>Interview on 04/05/18 the Licensee stated: She had two staff on each shift.</p> <p>-The shifts were eight hour shifts on the weekday Monday through Friday and 12 hour shifts on Saturday and Sunday. -She was not aware of the minimal staff requirements for this level of care.</p> <p>This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.</p>	V 304		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	VACANT PAGE DUE TO CONVERTING TO WORD DOCUMENT			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	VACANT PAGE DUE TO CONVERTING TO WORD DOCUMENT			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	VACANT PAGE DUE TO CONVERTING TO WORD DOCUMENT			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	VACANT PAGE DUE TO CONVERTING TO WORD DOCUMENT			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	<p>Continued From page 46</p> <p>27G .1805 Intensive Res. Tx. Child/ Adol - Operations</p> <p>10A NCAC 27G .1805 OPERATIONS</p> <p>(a) Each facility shall serve no more than 12 children or adolescents.</p> <p>(b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting.</p> <p>(c) Educational services within the facility shall be arranged and designed to maintain the educational and intellectual development of the child or adolescent. Treatment staff shall coordinate with the local education agency to ensure that the child or adolescent's educational needs are met as identified in the education plan.</p> <p>(d) Psychiatric consultation shall be available as needed for each child or adolescent.</p> <p>(e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer.</p> <p>(f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan.</p> <p>(g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year.</p>	V 305		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 47 This Rule is not met as evidenced by: Based on interview and record reviews and observations, the facility failed to ensure the educational services were made available to meet the clients' needs. The findings are: Review on 04/09/18 of client #2's record revealed: - 17 year old male. - Admission date of 02/27/18. - Diagnoses of Major Depression Disorder, Psychosis Disorder, Schizophrenia and Attention Deficit Hyperactivity Disorder (ADHD). - Person Centered Plan (PCP) updated on 01/26/18 revealed, Local DSS (Department of Social Services) custody, history of out of home placements, "treatment of his aggression and psychosis..history of responding to internal stimuli...becomes easily irritated by redirection...observed in both states of euphoria and withdrawn/depression...group home staff will facilitate structured activities and utilize behavior management system and regular verbal and written feedback to help resident better manage behaviors...therapist will engage resident in individual therapy in order to explore triggers for anger and other strong feelings and teach skills for more effectively managing anger, aggression and other impulsive behaviors. Therapist will facilitate group with resident and peers in order to increase positive communication and problem solving skills...have school on site." -No development and coordination with the Local Education Agency (LEA) to address the	V 305	V305 Measures in place to correct the deficiency: 1.Educational staff has been contracted to provide the educational component of the service. See attached copy of the educational staff person's contract 2.The curriculum has been approved in writing from the Robeson County School System. See the approval letter from the LEA regarding the curriculum 3.Educational staff will obtain IEP's for each of the consumer's and facilitate a meeting if/when the IEP is in needed of updating/revision. 4.Education staff will be responsible of reviewing each of the educational plans with the direct care staff. Measures in place to prevent reoccurrence of the problem: 1.CEO will ensure the position is filled. If the position becomes vacant, the CEO will immediately and vigorously begin recruitment to fill the position. Who is monitoring and how often to ensure the problem will not re-occur: CEO/Owner	2-02-18 4-25-18 Ongoing Ongoing Ongoing Ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 48 educational and intellectual needs. Review on 04/05/18 of client #3's record revealed: - 9 year old male. - Admission date of 03/17/18. - Diagnoses of Bipolar Disorder, Posttraumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Disorder, Encopresis and Rule Out Conduct Disorder. - Person Centered Plan (PCP) dated 04/26/17 revealed, "What's not working section; "Nothing is working, he continues to be aggressive and non-compliant. He is stealing food, his aggressive behaviors, mood swings, defiant-won't follow directions and rules and sexual behaviors/gestures, need constant supervision, medications not working, and he is not sleeping." "He bullies other peers...mother reported that [client #3] has pushed and hit her...mother expressed major concern about [client #3] touching his sister inappropriately. Mom reported that [client #3] stuck an object up his sister's butt. Mom and [client #3] reported that [client #3]'s father used to touch him inappropriately. [Client #3] stated he did that to his sister so she can feel how he feels...mom feels for the girls safety. Mom reports that [client #3] has choked her and his younger sister on more than one occasion...he often has major temper tantrums...he screams, yells, slam doors and hits others...[client #3] was involuntary committed on 12/11/17 after a physical altercation with the school staff. As a result of his aggressive behaviors he has pending charges with Dept. (department) of Juvenile Justice for disorderly conduct and assault on a government official...it was reported he is aggressive with staff at the hospital...[client #3] was released from the	V 305		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	<p>Continued From page 49</p> <p>hospital after 30 days..continues to be aggressive toward others...group home staff will support with use of CBT (cognitive behavioral therapy)...educate [client #3] and family on relapse prevention..teach techniques such as progressive relaxation, self-hypnoses, or biofeedback, ...teach behavioral alternatives...design a token economy...develop a contingency contract to improve [client #3]'s social skills...use a feeling chart..."</p> <p>- Medical Physician note dated 04/06/18, Assessment: needs higher level of care such as PTRF (Psychiatric Residential Treatment Facility). Review of staff notes on 3/20/18 - put in time out room, 3/20/18 - put in isolation environment, 3/24/18 - put in time out room, 04/03/18 sent to time out room, 04/04/18- found blade and cut himself.</p> <p>-No implementation or development of strategies to address sexually inappropriate behaviors, for constant supervision needs, no strategies implemented to address the use of CBT, family relapse prevention, progressive relaxation, self hypnoses or biofeedback, behavioral alternatives, development of a token economy, development of a contingency contract to improve social skills and no development of a feeling chart.</p> <p>-No development and coordination with the LEA to address the educational and intellectual needs.</p> <p>Review on 04/05/18 of client #4's record revealed:</p> <p>- 16 year old male.</p> <p>- Admission date of 03/07/18.</p> <p>- Diagnoses of Oppositional Defiant Disorder (ODD), PTSD, ADHD, Anxiety /Anger Issues, Conduct Disorder and Cannabis Use Disorder, Mild.</p> <p>- Person Centered Plan (PCP) dated 02/19/18 revealed, history of vandalism to mother's car,</p>	V 305		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	<p>Continued From page 50</p> <p>"beat car with a sledge hammer", stole guns from neighbors- found with multiple guns by law enforcement, broke into elderly resident's homes to steal and vandalized homes, hit his grandparents, and mother, and marijuana use...bullies others, 'let me have what I want, when I want it.' Goal: eliminate use of all substances.</p> <p>-No development and coordination with the LEA to address the educational and intellectual needs.</p> <p>Review on 04/09/18 of client #6's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 03/17/18. - Diagnoses of Unspecified Schizophrenia Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate. - PCP dated 08/03/17 revealed, "He threatens to hurt mom's dog that she uses as a service dog and other family pets...history of twisting mom's arm...He needs constant supervision...lack of remorse, his behaviors scare her (mom). He stole his father's truck and wrecked it...impulsiveness...does not see the danger...cruelty to people or animals, often bullies, threatens intimidates others, frequent lying...Link with [client #6]'s school to discuss implementation of his IEP and ensure he is on the best educational path...collaborate with therapist. Therapist will facilitate group with [client #6] and peers in order to increase positive communication and problem solving skills..." -No development and coordination with the Local Education Agency to address the educational and intellectual needs. 	V 305		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	Continued From page 51 Review on 04/05/18 of client #7's record revealed: - 14 year old male. - Admission date of 03/14/18. - Diagnoses of ADHD, Conduct Disorder, Disruptive Mood Disorder and Cannabis Use Disorder. - Person Centered Plan (PCP) dated 12/14/17 and assessment dated 03/14/18 revealed, " 'loved street life'- gang banging, smoking marijuana, history of IVC due to threats to kill family and others, his family is afraid of him...he can become extremely angry, easily irritated and argumentative and often blames others, he deliberately annoys others and attempts to intimidate them with threats of violence. history of being spiteful and vindictive as well as destruction of property, lying and leaving home without permission...threatened teachers to 'blow their brains out' and has also threatened his mother on several occasions that he was going to kill her. on the acute unit patient has displayed a quick temper, and has threatened to 'beat down' staff if they do not allow him to go home. Patient has significant DSS (department of social services) and DJJ (department of juvenile justice) involvement." "Group home staff will provide a safe and stable environment for [client #7] provide supervision and structure, utilize behavior management techniques, and create and implement corrective interventions to facilitate [client #7]'s improvement in demonstration of respect, management of anger and effective coping skills. [Client #7] will receive an individualized education based on needs, instruction in core curriculum and independent living skills, social skills, leisure skills, health and wellness training, and vocation skills through recreation activities five times per week...will	V 305		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 305	<p>Continued From page 52</p> <p>provide interaction to build competence and stability through evidence based individual therapy...monthly family therapy sessions with guardian..."</p> <p>-No implementation or development of strategies to address substance use/counseling and treatment, no implementation of strategies to address a safe and stable environment, or recreation activities or implementation of strategies to provide supervision and structure, no strategies developed or implemented to address a behavior management and no education plan developed or implemented. No health and wellness training strategies developed or implemented, no vocation skills strategies developed or implemented, and no evidence based individual therapy and monthly family therapy strategies implemented for client #7.</p> <p>-No development and coordination with the LEA to address the educational and intellectual needs.</p> <p>Interview on 04/05/18 client #2 stated: -The clients do worksheets for education/school at the facility.</p> <p>Interview on 04/05/18 client #3 stated: -They do not have "school" at the facility, "no school, no teacher."</p> <p>Interview on 04/05/18 client #4 stated: -" No school."</p> <p>Interview on 04/05/18 client #6 stated: -"No teachers here, no school yet."</p> <p>Interview on 04/05/18 client #7 stated: - "No school, the staff gives us worksheets."</p> <p>Interview on 04/05/18 staff #2 stated: -"We are trying to establish a regimen for</p>	V 305		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE <div style="background-color: black; height: 1.2em; width: 100%;"></div> LUMBER BRIDGE, NC 28357			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 305	<p>Continued From page 53</p> <p>education. We don't have a curriculum, no educational program. We use worksheets. No teacher yet."</p> <p>Interview on 04/12/18 staff #6 stated: -"We were told the boys were to have school work and therapy but no they just sat up there and watched TV all day. No teacher there, no school work, never seen it (school/education program), no workbooks, no teacher, nobody teaching nothing...that's all they had to do..."</p> <p>Interview on 04/09/18 staff #9 stated: -"I have never seen a teacher here or seen staff doing educational services. - The clients watch TV all day and talk among themselves."</p> <p>Interview on 04/09/18 staff #10 stated: -"I brought in math books. No educational services at all."</p> <p>Interview on 04/09/18 the Licensee stated: - She had no teacher in place to provide educational services to any of the clients. -She had not obtained IEP's (Individualized Educational Plan) for any of the clients at the facility and is working to get the IEP's for the clients; "I do it myself; I try to find a study guide." -She was not aware she needed to coordinate with the LEA for each of the clients residing at the facility.</p> <p>This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.</p>	V 305			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 54 27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 55 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 56</p> <p>available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement policy and to document their response to level II and III incidences. The findings are:</p> <p>See Tag V367 for specifics.</p> <p>Review on 04/05/18 of facility records from 02/01/18 through 04/13/18 of incidents not documented as level III revealed:</p> <ul style="list-style-type: none"> - 04/09/18 which involved client #7's allegation staff #6 pushed him, cursed him, threw water on him and attempted to strike him with a metal pole. - Incident (unknown specific date) of 03/2018 involved client #6 when staff #9 conducted a 	V 366	<p>V366</p> <p>Measures in place to correct the deficiency:</p> <p>1. Trained staff with the DMH Incident Reporting Manual; additional training for the staff with the Incident Reporting Policy, and the agency Standard of Operation related to Incident Reporting emphasizing the reporting timelines regarding response to level II and level III incidents and reporting to various agencies, including the MCO, Health Care Registry, etc. See Incident Reporting Policy See training certificates See Standard of Operation</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1. Continual review of medical record documentation to ensure any incidents that are noted have been appropriately reported and within timelines.</p> <p>2. Complete any warranted follow-up as a result of the review of medical records.</p> <p>3. Continual shadowing and monitoring of staff to give "hands on" training and advice immediately.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur:</p> <p>Clinical Director/LPC Qualified Professional Quality Management Director</p>	<p>4-21-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 57 harmful/abusive action of placing client #6's arm up and back into the client's back and escorted client #6 to the time-out room. -No policy implemented or documentation for response of level III incidents. Review from 04/05/18 through 04/13/18 revealed client #3 and client #6 were placed in the time out on at least 7 occasions with no documented response to incidences. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information;	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 58</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 59</p> <p>report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <ol style="list-style-type: none"> (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are.</p> <p>Review on 04/05/18 of facility records from 02/01/18 through 04/13/18 revealed:</p> <ul style="list-style-type: none"> - 04/09/18 which involved client #7's allegation staff #6 pushed him, cursed him, threw water on him and attempted to strike him with a metal pole. - Incident (unknown specific date) of 03/2018 involved client #6 when staff #9 conducted a harmful/abusive action of placing client #6's arm up and back into the client's back and escorted 	V 367	<p>V367</p> <p>Measures in place to correct the deficiency:</p> <p>1. Trained staff with the DMH Incident Reporting Manual; additional training for the staff with the Incident Reporting Policy, and the agency Standard of Operation related to Incident Reporting emphasizing the reporting timelines regarding response to level II and level III incidents and reporting to various agencies, including the MCO, Health Care Registry, etc. Also covered in the training is the correct steps in the completion of an internal investigation as a result of an incident.</p> <p>See Incident Reporting Policy See training certificates See Standard of Operation</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1. Continued review of medical record documentation to ensure any noted incidents have been/are reported appropriately and timely.</p> <p>2. Continue shadowing of staff to provide immediate feedback of best practice methods and responses to possible incidents.</p> <p>3. Follow-up with staff as needed as a result of the medical record reviews.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur:</p> <p>Clinical Director/LPC Quality Management Director Qualified Professional</p>	<p>4-21-18</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 60</p> <p>client #6 to the time-out room. -No level III incident reports were completed on above referenced incidents.</p> <p>Finding #1 Review on 04/13/18 of the IRIS (Incident Response Improvement System) revealed: -No IRIS report for incident on 04/09/18 was available for review at the completion of the survey process on 04/13/18.</p> <p>-No internal investigation was provided for the incident on 04/09/18 for review at the completion of the survey process on 04/13/18.</p> <p>Interview on 04/11/18 at the local hospital with client #7 who was under an IVC (involuntary commitment) order stated: Incident on 04/09/18 - "I was in [client #1]'s room she (staff 6) would come in and start stuff with us. She would cuss like cut the f*****g light off. [Client #1] had a phone. I called my mom and telling her what was happening. I think [staff #6] heard me calling my mom. I was playing with a soccer ball, it was loud. [Staff #6] said give me the f*****g ball. She put her fingers in my face and pushed me against the wall. I was mad. I kept throwing the ball hard against the wall. [Staff #6] said, I wish you would hit me as hard as you throw that ball. I went in [client #1]'s room and he was on the phone. I refused meds (medicines) that night, because I didn't know what she was going to do. I talked to [operations manager/group home manager] but he took up for [staff #6]. [Staff #6] came in [client #1]'s room [operations manager/group home manager] came in and told me to go to bed. She (staff #6) came in and threw water on me; a big cup with ice and water. It got on [client #1]'s bed and it was wet. I blanked out, she started swinging and</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 61</p> <p>hit me on the shoulder. I went to punch and I hit her. [Staff #14] came in and told me to go to bed. [Staff #6] came back in with a big pole. They took my bed out of my room and a rolling closet thing. She tried to hit me with it (the pole). She swung at me. She called the police and tried to press charges. [Staff #6] started crying when the police came." -The police took him to the hospital.</p> <p>Interview on 04/13/18 client #1 stated: - "[Client #7] was bored and was bouncing a ball on the wall. -[Staff #6] said, won't you hit me with that ball. - He came to my room to get away from [staff #6] and she followed him into my room and said to [client #7] go to your f*****g room. When he stood up she threw a cup of ice water on him and on my bed everywhere. He punched her in the face. She grabbed a pole and tried to hit him, swinging at him. [Operations Manager/ Group Home Manager] was holding her back and the police came. -[Staff #6] always cuss at us and at everybody; said (to client #7), I'll f***k you up little boy and tried to throw his clothes outside."</p> <p>Interview on 04/09/18 staff #10 stated: - "[Staff #6], a certain staff agitates the kids, yells and curses at them. - [Staff #6] would also poke at [client #7] and upset him, make him angry."</p> <p>Interview on 04/12/18 staff #6 stated: - "I was assaulted there at the group home. - Two women on staff with 7 boys getting out of control (incident On 04/09/18). - [Client #7] caught attitude, cussing, throwing his stuff against the wall, got in my face. I called [operations manager/group home manager] to</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 62</p> <p>come to the group home...I felt unsafe with 7 boys.</p> <ul style="list-style-type: none"> - [Client #7] refused his meds (medications) and I told [client #7] to go to bed and I had a bottle of water in my hand and waving my hands and he said don't pour water on me; some of the water spilled on his feet and [staff #4] called me (date unknown) and asked me why I poured water on him. They put me in a unsafe place. He (client #7) punched me in the face and injured my left eye, hit me with a closed fist and broke my glasses and I got gashes on my face around my eye and optical bone is fractured... - [Staff #4] came out to see my face and to do IVC order on [client #7]... - [Operations manager/group home manager] told [staff #4] I poured water on him (client #7), and in his face... - [Operations manager/group home manager] tackled [client #7] after [client #7] attacked me. - We took [client #7]'s bed out and rolling closet 'cause [client #7] was tearing it up. - A bar, broke off the closet, a metal closet piece; I didn't do nothing to him with no metal pole (staff #6 laughed). - I just reacted on pure emotion, I just went to get him and they had to hold me back but I didn't hit him, couldn't get to him, never hit him, couldn't get to him, [operations manager/group home manager] held me back." - "I was cursing at him (client #7) well generally, because I was hurt..." <p>Finding #2</p> <p>Review on 04/09/18 of client #6's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 03/17/18. - Diagnoses of Unspecified Schizophrenia 	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 63</p> <p>Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate.</p> <p>- PCP dated 08/03/17 revealed, "He threatens to hurt mom's dog that she uses as a service dog and other family pets...history of twisting mom's arm...He needs constant supervision...lack of remorse...impulsiveness...does not see the danger...cruelty to people or animals, often bullies, threatens intimidates others, frequent lying..."</p> <p>Interview on 04/05/18 client #6 stated: -You go to the time out room 'cause not behaving, staff [staff #10] said I had a bad attitude." -"[Staff #9] went into my pocket and took my iPod."</p> <p>Interview on 04/10/18 staff #9 stated: -He had not received any NCI (North Carolina Intervention) training at the facility. - "One staff allowed him (client #6) to have cell phone, iPhone or something like that and I told him he couldn't have it. -I told him he couldn't have it and I told him I needed to get it from him. -He got combative on me and I put him in a therapeutic hold and put him, walked him, to time out room to calm down; 10-15 min (minutes)...hold was left arm up and into his back. -Can't explain, nothing life threatening, just a restraint in Early March (2018). -Never been told to write up anything at all about a restraint..."</p> <p>-No IRIS report for incident on 03/2018 was available for review at the completion of the</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 64</p> <p>survey process on 04/13/18.</p> <p>-No internal investigation was provided for the incident on 03/2018 for review at the completion of the survey process on 04/13/18.</p> <p>Finding #3</p> <p>Review on 04/11/18 of local police reports revealed: 03/28/18 - "Caller advised that one of the children at the group home threw a rock through the windshield of her 2014 black ford 150." 04/02/18 - DSS called out/ local Detective assigned. - No level II reports completed in IRIS to reflect these police involved incidents.</p> <p>Finding #4</p> <p>Interviews on 04/09/18 with client #3 and client #6 revealed they were placed in the time out room on multiple occasions.</p> <p>Interviews from 04/05/18 through 04/13/18 with all staff revealed time out room was used on multiple occasions for client #3 and client #6.</p> <p>Review from 04/05/18 through 04/13/18 revealed no documentation of incident reports for use of the time out room.</p> <p>Multiple interview attempts were made to interview the Operations Manager/Group Home Manager in regards to the allegation on 04/09/18 and incident on 03/2018. There was no response from the Operations Manager/Group Home Manager at the completion of the survey process on 04/13/18.</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 65 Interview on 04/09/18 the Licensee stated: -She was aware of an IVC for client #7 due to an assault on staff #6 on 04/09/18 and client #7's allegation against staff #6 on 04/09/18. - The IRIS reports were in process to be completed for the incidents on 03/2018 and 04/09/18. - No IRIS reports were completed by the completion of the survey process on 04/13/18. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.	V 367		
V 503	27D .0103 Client Rights - Search And Seizure Policy 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized; and (5) an account of the disposition of seized property.	V 503		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 503	<p>Continued From page 66</p> <p>This Rule is not met as evidenced by: Based on interview and record review the facility conducted unwarranted search and seizure affecting one of five audited clients (#6). The findings are:</p> <p>Review on 04/09/18 of client #6's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 03/17/18. - Diagnoses of Unspecified Schizophrenia Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate. - PCP dated 08/03/17 revealed, "He threatens to hurt mom's dog that she uses as a service dog and other family pets...history of twisting mom's arm...He needs constant supervision...lack of remorse, his behaviors scare her (mom). He stole his father's truck and wrecked it...impulsiveness...does not see the danger...cruelty to people or animals, often bullies, threatens intimidates others, frequent lying..." <p>Interview on 04/05/18 client #6 stated:</p> <ul style="list-style-type: none"> - "You go to the time out room 'cause not behaving, staff [staff #10] said I had a bad attitude." - "[Staff #9] went into my pocket and took my iPod and locked it up." <p>Interview on 04/10/18 staff #9 stated:</p> <ul style="list-style-type: none"> - "One staff allowed him (client #6) to have cell phone iPhone or something like that and I told him, he couldn't have it." - I told him he couldn't have it and I told him I 	V 503	<p>V503</p> <p>Measures in place to correct the deficiency:</p> <ol style="list-style-type: none"> 1. Revised New Horizon Search and Seizure Policy to include statement regarding following reporting timelines. See attached copy of New Horizon Search and Seizure Policy 2. Train staff on the Search and Seizure Policy. 3. Train staff on the DMH Incident Reporting Manual relevant to reporting of search and seizure incidents. <p>Measures in place to prevent reoccurrence of the problem:</p> <ol style="list-style-type: none"> 1. Continued monitoring of the staff and provide "hands-on" oversight in order to give immediate feedback. 2. Continued review of medical record documentation to ensure any noted incidents have been responded to appropriately and reported timely. 3. Follow-up in staff meetings and/or individual supervisions with staff if warranted. <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Qualified Professional Quality Management Director</p>	<p>5-03-18</p> <p>Prior to 5-12-18</p> <p>4-21-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 503	Continued From page 67 needed to get it from him. -He got combative on me and I put him in a therapeutic hold and put him, walked him to time out room to calm down; 10-15 min (minutes)...hold was left arm up and into his back. -Can't explain, nothing life threatening, just a restraint, in early March (2018). -Never been told to write up anything at all about a restraint..." No documentation of a search and seizure to include, scope of search, reason for search, procedures followed in the search, a description of any property seized and an account of the disposition of seized property conducted by staff #9 on 03/2018 was available for review. Interview on 04/10/18 the Licensee stated: -She was unaware a search and seizure had taken place with client #6. This deficiency is crossed referenced into 10A NCAC 27G .1801 SCOPE (V301) for a Type A1 rule violation.	V 503		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 68</p> <p>necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, two of six audited staff (#9, #6) subjected two of five audited clients (#6, #7) to harm and abuse. The findings are:</p> <p>Finding #1 Review on 04/09/18 of client #7's record revealed: - 14 year old male. - Admission date of 03/14/18. - Diagnoses of ADHD, Conduct Disorder, Disruptive Mood Disorder and Cannabis Use Disorder. - Person Centered Plan (PCP) dated 12/14/17 and assessment dated 03/14/18 revealed, " 'loved street life'- gang banging, smoking marijuana, history of IVC due to threats to kill family and others, his family is afraid of him...he can become extremely angry, easily irritated and argumentative and often blames others, he deliberately annoys others and attempts to intimidate them with threats of violence. history of being spiteful and vindictive as well as destruction of property, lying and leaving home without permission...threatened teachers to 'blow</p>	V 512	<p>V512</p> <p>Measures in place to correct the deficiency: 1. Client Rights training was provided with all staff. 4-21-18 2. NCI training was completed with all staff. See training certificates 4-14-18 3. Completed training relevant to "how to complete internal investigations" during the Incident Reporting Manual training. Also, completed review training regarding the Standard of Operation for Incident Reporting that has steps for completion of internal investigations. See Incident Reporting training certificates 4-21-18</p> <p>Measures in place to prevent reoccurrence of the problem: 1. Continued shadowing and monitoring of staff in order to provide immediate feedback regarding appropriate behavior modifications. Ongoing 2. Review of medical record documentation to ensure any noted incidents were appropriately handled and reported timely. Ongoing 3. Follow-up with any warranted issues in staff meetings and/or individual supervisions. Ongoing</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Qualified Professional Quality Management Director Ongoing</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 69</p> <p>their brains out' and has also threatened his mother on several occasions that he was going to kill her... has threatened to 'beat down' staff..."Group home staff will provide a safe and stable environment for [client #7] provide supervision and structure, utilize behavior management techniques, and create and implement corrective interventions to facilitate [client #7]'s improvement in demonstration of respect, management of anger and effective coping skills. [Client #7] will receive an individualized education based on needs, instruction in core curriculum and independent living skills, social skills, leisure skills, health and wellness training, and vocation skills through recreation activities five times per week...will provide interaction to build competence and stability through evidence based individual therapy...monthly family therapy sessions with guardian..."</p> <p>Review on 04/05/18 of a North Carolina Incident Response Improvement System (IRIS) report completed by the Operation Manager/Group Home Manager revealed:</p> <ul style="list-style-type: none"> - Date of incident: 03/31/18. - Incident Comments: dated 04/03/18 "I [operations manager/group home manager] received a call from staff member [staff #10] at approximately 9pm on 3/31/18 reporting that consumer [client #7] was allegedly choked by staff member [staff #9]. I relieved [staff #9] of his duties until the internal investigation can be completed, but at this time neither the consumer nor the other staff member [staff #13] on duty indicated any knowledge of the alleged incident reported by [staff #10]. There were no visible marks on the consumer and the consumer repeatedly indicated that he was fine and had no complaints. Even when following up with the 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 70</p> <p>consumer on today he indicated there was no incident. Investigation is currently ongoing as DSS was onsite today and we are awaiting their findings as well."</p> <p>- "Describe the cause of this incident: completed on 4/3/18- staff member accused another member of physically abusing a consumer (client #7). Internal investigation is being conducted as well as DSS having come out to conduct their own investigation.</p> <p>- "Incident Prevention: completed on 4/3/18 - At this time we are not sure what could have been done differently and are still investigating the matter further. The management team will be review policy & procedures to determine if they need to be update."</p> <p>-No internal investigation was provided for the incident on 03/31/18 for review on the completion of the survey process on 04/13/18.</p> <p>Interview on 04/05/18 and 04/11/18 and observation at approximately 3:15 pm at the local hospital client #7 stated:</p> <p>4/05/18 - "no staff hit me, pushed me, nothing to talk about."</p> <p>4/11/18 - while client #7 was under Involuntary Comittment (IVC) order at a local hospital, "If I tell you (DHSR surveyors) they (group home staff) they were going to shut the place (facility) down and send us to level four or five."</p> <p>-Incident on 03/31/18, "[staff #9] came in with attitude around 7(pm) we were eating.</p> <p>-He said don't f **k with me today.</p> <p>-He picked me out of the bunch and said what the f**k you laughing at.</p> <p>-He said he had an attitude because he couldn't go home with family.</p> <p>-He told me to go to my room, then he said go to</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 71</p> <p>the living room.</p> <p>-He said why aren't you going to your room.</p> <p>-He pushed me against the wall; He wasn't hurting me so I laughed.</p> <p>-He was hitting me, then he choked me and I was yelling for help."</p> <p>-Observation of client #7 at 3:15pm he demonstrated a choke hold to his neck with both hands around the front of his neck.</p> <p>-"[Staff #10] told [staff #9] to get off me.</p> <p>-[Staff #9] told him that only 1 staff need to be in the room and [staff #10] said no not in a situation like this.</p> <p>-(Staff #9) had both hands around his neck, he let me go and</p> <p>I ran around to other side of the bed.</p> <p>-He (staff #9) hit and slapped me.</p> <p>- I saw a pistol on his side. It was a black handle, [staff #10] saw it and [client #1] saw it."</p> <p>Interview on 04/13/18 client #1 stated:</p> <p>-The incident with "[staff #9] and [client #7] "I didn't see what happened, but I saw the gun, the handle in his pocket. [Staff #9] took it out of his book bag and put it on like in his pants, like the band of his pants and you could see the handle sticking out, it was black."</p> <p>Interview on 04/05/18 client #2 stated:</p> <p>- "I just heard [staff #9] and [client #7] arguing.</p> <p>- [Staff #9] got mad at [staff #10], 'cause [staff #10] was leaving and threw the keys on the table...[staff #9] got something out of his book bag, I watched him get it out and it looked like a gun because [client #7] threatened him.</p> <p>-[Client #1] and [client #7] said it was a gun.</p> <p>-[Staff #8] said he wouldn't let nothing happen to us and that he would go and get his gun but he didn't threaten nobody.</p> <p>-[Staff #9] hit the table 'cause he was mad.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 72</p> <p>-[Client #7] said [staff #9] slapped him and I believe him. -[Staff #9] was in his (client #7's) room."</p> <p>Interview on 04/05/18 client #4 stated: - "I heard some stuff; But [staff #10] told me to stay in my room. -I heard [client #7] yelling, maybe around Easter Sunday, didn't see anything don't know why he was arguing with [staff #9]. -Staff raise their voice a little bit to get through to the clients." - Staff #9 and staff #10 only staff on duty during incident.</p> <p>Interview on 04/05/18 staff #2 stated: - "I came in on Easter Sunday morning (04/01/18) and [client #7] said he and [staff #9] got in a confrontation, argument. -[Client #7] got out of hand and [staff #9] had to put him in his place. -[Client #7] said [staff #9] was cursing at him and he may have felt intimidated by [staff #9] 'cause [staff #9] is big in statute...[staff #9] is 300 to 400 pounds and 6' 4"... and would intimidate any child...no one told me anything. -No weapons allowed here."</p> <p>Staff #13 was not available during interview survey process and no contact information was provided by the Licensee.</p> <p>Interview on 04/09/18 staff #10 stated: - On 3/31/18, he began work at 8am and staff #9 was going off shift; "no other staff but me there with 7 clients...I was still only staff on at 4:30 to 5 on 03/31/18." - Incident on 03/31/18 - " [Staff #9] came in 6 to 6:30 (pm), his wife dropped him off. -[Staff #13] came in at 4:30 to 5 on 03/31/18.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 73</p> <p>-[Staff #9] yelling, I'm gonna beat your a*s and m****r f****r. [Staff #9] goes to [client #7]'s room and I hear, boom.</p> <p>-I go to [client #7]'s room, [staff #9] is doing the like balled up fists, like boxing stance, [client #7] was crying and [staff #9] asked me to step out and I said no, need two staff and [staff #9] with open hand hit [client #7] in the face and [client #7] flew across his bed and hit knocked down on his bed.</p> <p>- Told [staff #9] to leave the room and he tried to hug [client #7] and talk to him about nonsense.</p> <p>- [Staff #9] was yelling, I was told to f*****g do this.</p> <p>-I had [client #7] in the room and [staff #9] went into the office.</p> <p>-I told everybody to clear the hallway.</p> <p>- [Client #1] beacons to me with his eyes motioned for me.</p> <p>-[Client #1] said he has a gun (staff #9) and he saw it...I asked [staff #9] if he had a fire arm and he said no, search my bag...</p> <p>-In his room [client #7] was saying to me yo, he's choking me.</p> <p>-I saw his (staff #9) hands at his (client #7)'s neck but saw the slap to [client #7]'s face and it knocked him across the bed.</p> <p>-I called [Former QP (Qualified Professional)] and I called [operations manager/group home manager] and told him about this situation; it was 8:20pm and at 7:15 incident happened.</p> <p>- [Staff #13] was locked up in the kitchen.</p> <p>-I asked about incident report, called [Licensee] and no answer, no voice mail and texted [Licensee] about what needs to be done.</p> <p>- It was 9pm.</p> <p>-I didn't see a firearm."</p> <p>- "No call back from [operations manager/group home manager] or [Licensee]...</p> <p>- [Operations manager/group home manager]</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 74</p> <p>sent me a text at 10:15- 10:18 and said don't come in Easter Sunday at 8A(am) and I was scheduled.</p> <p>-I looked on line and law says to report it.</p> <p>-I had no training on what to do...[staff #4] is going around telling staff not to say anything about the incident."</p> <p>- Three staff on shift during the incident with 7 clients in the facility.</p> <p>Interview on 04/09/18 staff #9 stated:</p> <p>-Incident on 03/31/18 - "4:30 to 5:00 I came in and [client #7] declined his meds.</p> <p>-He was agitated not his self, he was combative with staff and clients and [Former QP] and [staff #4] took the TV from the clients as a punishment for behaviors, another staff elected to give the TV back on Saturday 3/31/18...</p> <p>-[Client #7] was getting disrespectful and I told him to go to his room to calm down and he cursed, M***** F***** and all this.</p> <p>-I stand up, I'm 6' 2" and 370 pounds, a big guy.</p> <p>- [Client #7] on couch gets up and goes to his room and I follow him.</p> <p>- He sits down on the bed; I'm always able to talk to these guys and calm them down, he's on edge, so I hear behind me and [staff #10] walks in and says [staff #4] said to have 2 staff, and [client #7] jumped at me.</p> <p>-I took him by his shirt and held him against the wall.</p> <p>-I asked him, man what's going on.</p> <p>- I took my hands off him, he was crying and sat on the bed.</p> <p>-[Staff #10] walks out behind me...[client #7] came out and watched TV like nothing happened.</p> <p>- No, choke, not at all.</p> <p>-I have big hands and it may look like my hands were near his throat, just being honest.</p> <p>-Oh no, negative, no abuse not at all.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 75</p> <ul style="list-style-type: none"> -No slap across the face; I have big hands and I'm a big man, if I would have done anything at all the markings would still be there... -[Staff #4] called me on Monday (04/02/18) to tell me I'm suspended about a allegation of assault... -I am a convicted felon myself, firearm, don't own a firearm. -I put everything in my sweat pant's pockets, that day in question, where would I have put it, no holster. -If I had a ink pen it would have fallen out. -I don't carry firearms or knives. -I do carry in my bag, a box cutter; I carry one of those to the facility because of the area..." <p>Interview on 04/05/18 the Operations Manager/Group Home Manager stated:</p> <ul style="list-style-type: none"> - He had worked at the facility for one week. - He was aware client #7 had made abuse allegations against staff #9 on 03/31/18. - He had begun the internal investigation of the abuse allegations on 03/31/18. <p>Interview on 04/10/18 and 4/13/18 the Licensee stated:</p> <ul style="list-style-type: none"> - She was unsure as to why the operations manager/group home manager had not completed the internal investigation for incident on 03/31/18, "maybe he didn't write it all up." - Staff #9 will be terminated from his position as a result of the allegation on 03/31/18. <p>Finding #2</p> <p>Review on 04/13/18 of the IRIS system revealed:</p> <ul style="list-style-type: none"> -No IRIS report for incident on 04/09/18 was available for review at the completion of the survey process on 04/13/18. 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 76</p> <p>-No internal investigation was provided for the incident on 04/09/18 for review at the completion of the survey process on 04/13/18.</p> <p>Interview on 04/11/18 at the local hospital under IVC order client #7 stated: Incident on 04/09/18 - "I was in [client #1]'s room she (staff 6) would come in and start stuff with us. - She would cuss like cut the F-----light off. -[Client #1] had a phone; I called my mom and telling her what was happening. -I think [staff #6] heard me calling my mom. - I was playing with a soccer ball, it was loud. -[Staff #6] said give me the F-----ball. -She put her fingers in my face and pushed me against the wall. -I was mad. - I kept throwing the ball hard against the wall. -[Staff #6] said I wish you would hit me as hard as you throw that ball. -I went in [client #1]'s room and he was on the phone. -I refused meds that night, because I didn't know what she was going to do. - I talked to [operations manager/group home manager] but he took up for [staff #6]. -[Staff #6] came in [client #1]'s room [operations manager/group home manager] came in and told me to go to bed. - She (staff #6) came in and threw water on me; a big cup with ice and water. -It got on [client #1]'s bed and it was wet. - I blanked out, she started swinging and hit me on the shoulder. -I went to punch and I hit her. -[Staff #14] came in and told me to go to bed. - [Staff #6] came back in with a big pole. -They took my bed out of my room and a rolling closet thing.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 77</p> <ul style="list-style-type: none"> -She tried to hit me with it (pole); she swung at me. -She called the police and tried to press charges. -[Staff #6] started crying when the police came." -The police took him to the hospital. <p>Interview on 04/13/18 client #1 stated:</p> <ul style="list-style-type: none"> - "[Client #7] was bored and was bouncing a ball on the wall. -[Staff #6] said, won't you hit me with that ball. - He came to my room to get away from [staff #6] and she followed him into my room and said to [client #7] go to your f*****g room and when he stood up she threw a cup of ice water on him and on my bed everywhere. He punched her in the face. She grabbed a pole and tried to hit him, swinging at him. [Operations Manager/ Group Home Manager] was holding her back and the police came. -[Staff #6] always cuss at us and at everybody, said (to client #7), I'll f**k you up little boy and tried to throw his clothes outside." <p>Interview on 04/09/18 staff #10 stated:</p> <ul style="list-style-type: none"> - "[Staff #6], a certain staff agitates the kids, yells and curses at them. - [Staff #6] would also poke at [client #7] and upset him, make him angry." <p>Interview on 04/12/18 staff #6 stated:</p> <ul style="list-style-type: none"> - " I was assaulted there at the group home. - Two women on staff with 7 boys getting out of control (incident On 04/09/18). - [Client #7] caught attitude, cussing, throwing his stuff against the wall, got in my face. I called [operations manager/group home manager] to come to the group home...I felt unsafe with 7 boys. - [Client #7] refused his meds (medications) and I told [client #7] to go to bed and I had a bottle of 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 78</p> <p>water in my hand and waving my hands and he said don't pour water on me; some of the water spilled on his feet and [staff #4] called me (date unknown) and asked me why I poured water on him. They put me in a unsafe place. He (client #7) punched me in the face and injured my left eye, hit me with a closed fist and broke my glasses and I got gashes on my face around my eye and optical bone is fractured...</p> <ul style="list-style-type: none"> - [Staff #4] came out to see my face and to do IVC order on [client #7]... - [Operations manager/group home manager] told [staff #4] I poured water on him (client #7), and in his face... - [Operations manager/group home manager] tackled [client #7] after [client #7] attacked me. - We took [client #7]'s bed out and rolling closet 'cause [client #7] was tearing it up. - A bar, broke off the closet, a metal closet piece; I didn't do nothing to him with no metal pole (staff #6 laughed). - I just reacted on pure emotion, I just went to get him and they had to hold me back but I didn't hit him, couldn't get to him, never hit him, couldn't get to him, [operations manager/group home manager] held me back." - "I was cursing at him (client #7) well generally, because I was hurt..." <p>Finding #3</p> <p>Review on 04/09/18 of client #6's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 03/17/18. - Diagnoses of Unspecified Schizophrenia Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 79</p> <p>Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate.</p> <p>- PCP dated 08/03/17 revealed, "He threatens to hurt mom's dog that she uses as a service dog and other family pets...history of twisting mom's arm...He needs constant supervision...lack of remorse, his behaviors scare her (mom). He stole his father's truck and wrecked it...impulsiveness...does not see the danger...cruelty to people or animals, often bullies, threatens intimidates others, frequent lying..."</p> <p>Interview on 04/05/18 client #6 stated: -You go to the time out room 'cause not behaving, staff [staff #10] said I had a bad attitude." -"[Staff #9] went into my pocket and took my iPod."</p> <p>Interview on 04/10/18 staff #9 stated: -He had not received any NCI (North Carolina Intervention) training at the facility. - "One staff allowed him (client #6) to have cell phone, iPhone or something like that and I told him, he couldn't have it. I told him he couldn't have it and I told him I needed to get it from him. He got combative on me and I put him in a therapeutic hold and put him, walked him to time out room to calm down; 10-15 min (minutes)...hold was left arm up and into his back. Can't explain, nothing life threatening, just a restraint. Early March (2018). Never been told to write up anything at all about a restraint..."</p> <p>Multiple interview attempts were made to interview the Operations Manager/Group Home Manager in regards to the allegation on 04/09/18; there were no response from the Operations Manager/Group Home Manager at the completion of the survey process on 04/13/18.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 80</p> <p>Interview on 04/09/18 the Licensee stated: -She was aware of an IVC for client #7 due to an assault on staff #6 on 04/09/18. - The IRIS reports were in process to be completed for the incidents. - No IRIS reports were completed by the completion of the survey process on 04/13/18.</p> <p>Review on 04/10/18 of the Plan of Protection dated 04/10/18 completed by the Licensee revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? -"All staff will be trained and re-trained in client rights by QA/QI (Quality Assurance/Quality Improvement) with potential hire of LP (Licensed Professional) by 4/30/18. Will explore implementing video surveillance for the facility by 4/30/18 by the Licensee and I am recruiting more staff with adolescent experience by 4/30/18." Describe your plans to make sure the above happens: -"Will schedule with QA/QI staff to be training immediately with staff. I'm exploring companies with video equipment to be installed at the facility. I'm in process of recruiting more qualified staff."</p> <p>The incidents of abuse on client #7 occurred on 03/31/18 by staff #9 and on 04/09/18 by staff #6 and on client #6 by staff #9 on 03/2018.</p> <p>On 03/31/18 Staff #9 abused client #7 by grabbing him by the shirt holding him up against a wall and hitting/slapping/choking him. And on another occasion (03/2018 exact date unidentified) staff #9 placed client #6 in a hold (staff #9 was not trained on North Carolina Interventions(NCI)) which included having the client's arm behind his back and pushed up into</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 81 his back while staff escorted the client to the Isolation Time-Out room. On 04/09/18 staff #6 abused client #7 by throwing water on him and putting her fingers in his face and pushing him and attempting to hit him with a metal pole. Staff had to intervene and "hold her back." The actions of the staff resulted in serious harm and abuse to clients #2 and #7. This deficiency constitutes a Type A1 rule violation for serious harm and abuse.	V 512		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	Continued From page 82 This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to provide services/supports which promoted a safe and respectful environment including utilizing the least restrictive and most appropriate setting and methods affecting 2 of 5 audited clients (#3 and #7). The findings are: Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V520). Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required provisions affecting 2 of 7 clients (#3, #6). Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V521). Based on record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control to include documentation, notation of client's physical and psychological well-being, rationale for use and description of the intervention, debriefing and planning, affecting 2 of 7 clients. Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V522). Based on observation, record reviews	V 513	V513: Measures in place to correct the deficiency: 1. During NCI (alternatives to restrictive interventions) and Client Rights training, staff were informed/reminded the room that was used as a time-out room is not to be used. The agency does not provide time-out. As a result, the room has been converted to a "study" area with computers for the consumers to use. See training certificates Measures in place to prevent reoccurrence of the problem: 1. Continued shadowing and monitoring of staff to provide immediate feedback regarding behavior modifications. 2. Continued medical record reviews to ensure noted incidents have been responded to appropriately and reported timely. 3. Completed any warranted follow-up during staff meetings and/or individual supervisions. Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Qualified Professional Quality Management Director	4-14-18 4-21-18 Completed prior to 4-30-18 Ongoing Ongoing Ongoing Ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	<p>Continued From page 83</p> <p>and interviews, the facility failed to maintain a time-out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions as an emergency use of a restrictive intervention, approved staff to administer intervention, conduct assessment which includes the physical and psychological well-being of the client and obtain a written order for time-out affecting 2 of 7 clients (#3, #6).</p> <p>Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V523). Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include periodic observation of at least every 15 minutes, provision to the use of the toilet, documentation in the client record and a facility staff with no other immediate responsibility other than to monitor client who is placed in time, provide continuous observation and verbal interaction affecting 2 of 7 clients (#3, #6).</p> <p>Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V524). Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include the required documentation, required notification, an order for the use of the restrictive intervention and</p>	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	<p>Continued From page 84</p> <p>the written approval of the designee of the governing body, affecting 2 of 7 clients (#3, #6).</p> <p>Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V525). Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include, reviews and reports of any and all restrictive interventions, a regular review by a designee and by the Client Rights Committee and an investigation of any unusual or possible unwarranted patterns of use and documentation log with required information, positive and less restrictive alternatives used or considered and debriefing and planning with the required persons and the negative effects of the restrictive intervention and any impact on the physical and psychological well-being of the client affecting 2 of 7 clients (#3, #6).</p> <p>Cross Reference: 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (V526). Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include, failed to collect and analyzing data on the use of the restrictive intervention, document the type of procedure used and length of time employed, document alternatives considered and</p>	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	<p>Continued From page 85</p> <p>effectiveness, affecting 2 of 7 clients (#3, #6).</p> <p>Cross Reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536). Based on record reviews and interview, the facility failed to implement policy to ensure six of six audited staff (#2, #3, #6, #9, #10 and the Operations Manager/Group Home Manager) received initial training in alternatives to restrictive interventions.</p> <p>Cross Reference: 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (V537). Based on record reviews and interview, the facility failed to ensure six of six audited staff (#2, #3, #6, #9, #10 and the Operations Manager/Group Home Manager) received training in seclusion, physical restraint and isolation time-out only by staff who have been trained and demonstrated competence and prior to providing direct care to people with disabilities.</p> <p>Review on 04/10/18 of the Plan of Protection dated 04/10/18 completed by the Licensee revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? -"Training will be given to all staff that time out will not be used, by QA (quality assurance) trainer by 4/14/ and 4/21 (2018) training all trained." Describe your plans to make sure the above happens: -"Will contact QA staff for training on time out room, will not be utilized."</p> <p>A nine year old client #3 who has diagnoses of Bipolar Disorder, Posttraumatic Stress Disorder (PTSD), ADHD, Disruptive Mood Disorder,</p>	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	Continued From page 86 Encopresis and Rule Out Conduct Disorder and a 14 year old client #7 who has diagnoses of ADHD, Conduct Disorder, Disruptive Mood Disorder and Cannabis Use Disorder were placed in an unapproved time-out room and left unattended by staff for up to at least 15 minutes on at least 7 different documented occasions. Both staff and clients report the use of the unapproved time-out room. Clients were locked in the room. This room was not approved as a time-out room during initial licensure. Staff used the room as a punishment and threatened to use the room in an attempt to control and deter behaviors. None of the staff have been trained in the use of restrictive interventions including use of time-out procedures. Staff failed to document the use of the time out room, physical assessment/psychological well-being of the client, rational for use, documentation log, collect and analyze data, obtain medical orders, maintain staff in attendance, ensuring safety and harm free use while utilizing the time out room, notification requirements, reports and reviews requirements of the use of the time out room and establish the required policy and procedures for the use of a time out room. Due to clients being locked in an unapproved time-out room by staff who were not trained in its use, lack of monitoring while in the time-out room, lack of clients' psychological well-being, lack of all required documentation on use of a time out room this deficiency constitutes a Type A1 for serious harm and abuse.	V 513		
V 520	27E .0104 (e8) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL	V 520		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 520	<p>Continued From page 87</p> <p>(e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions:</p> <p>(8) any room used for seclusion or isolation time-out shall meet the following criteria:</p> <p>(A) the room shall be designed and constructed to ensure the health, safety and well-being of the client;</p> <p>(B) the floor space shall not be less than 50 square feet, with a ceiling height of not less than eight feet;</p> <p>(C) the floor and wall coverings, as well as any contents of the room, shall have a one-hour fire rating and shall not produce toxic fumes if burned;</p> <p>(D) the walls shall be kept completely free of objects;</p> <p>(E) a lighting fixture, equipped with a minimum of a 75 watt bulb, shall be mounted in the ceiling and be screened to prevent tampering by the client;</p> <p>(F) one door of the room shall be equipped with a window mounted in a manner which allows inspection of the entire room;</p> <p>(G) glass in any windows shall be impact resistant and shatterproof;</p> <p>(H) the room temperature and ventilation shall be comparable and compatible with the rest of the facility; and</p> <p>(I) in a lockable room the lock shall be interlocked with the fire alarm system so that the door automatically unlocks when the fire alarm is activated if the room is to be used for seclusion.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the</p>	V 520		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 520	Continued From page 88 required provisions affecting 2 of 7 clients (#3, #6). The findings are: Review on 04/05/18 of client #3's record revealed: - 9 year old male. - Admission date of 03/17/18. - Diagnoses of Bipolar Disorder, Posttraumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Disorder, Encopresis and Rule Out Conduct Disorder. - Person Centered Plan (PCP) dated 04/26/17 revealed, "What's not working section; "Nothing is working, he continues to be aggressive and non-compliant. He is stealing food, his aggressive behaviors, mood swings, defiant-won't follow directions and rules and sexual behaviors/gestures, need constant supervision, medications not working, and he is not sleeping." "He bullies other peers...mother reported that [client #3] has pushed and hit her...mother expressed major concern about [client #3] touching his sister inappropriately. Mom reported that [client #3] stuck an object up his sister's butt. Mom and [client #3] reported that [client #3]'s father used to touch him inappropriately. [Client #3] stated he did that to his sister so she can feel how he feels...mom feels for the girls safety. Mom reports that [client #3] has choked her and his younger sister on more than one occasion...he often has major temper tantrums...he screams, yells, slam doors and hits others...[client #3] was involuntary committed on 12/11/17 after a physical altercation with the school staff. As a result of his aggressive behaviors he has pending charges with Dept. (department) of Juvenile Justice for disorderly conduct and assault on a government official...it was reported he is aggressive with staff	V 520	V520 Measures in place to correct the deficiency: 1.NCI (alternative to restrictive interventions) training was provided for the staff. See training certificates 2.The staff will be trained on the New Horizon Restrictive Intervention Policy reflecting no use of isolation or use of time-out. See Restrictive Intervention Policy 3.Client Rights was provided to the staff. See training certificate 4.Re-designed the room that had been wrongly used as a time-out room. The room has been re-designed as a study area with computers for the consumers use. Measures in place to prevent reoccurrence of the problem: 1.Continued monitoring and shadowing of the staff to provide immediate feedback regarding appropriate behavior modifications. 2.Follow-up any issues in staff meetings and/or individual supervisions, as warranted. Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Quality Management Director Qualified Professional	4-14-18 Prior to 5-12-18 4-21-18 Completed prior to 4-30-18 Ongoing Ongoing Ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 520	<p>Continued From page 89</p> <p>at the hospital...[client #3] was released from the hospital after 30 days..continues to be aggressive toward others...group home staff will support with use of CBT (cognitive behavioral therapy)...educate [client #3] and family on relapse prevention..teach techniques such as progressive relaxation, self-hypnosis, or biofeedback, ...teach behavioral alternatives...design a token economy...develop a contingency contract to improve [client #3]'s social skills...use a feeling chart..."</p> <p>- Medical Physician note dated 04/06/18, Assessment: needs higher level of care such as PTRF (Psychiatric Residential Treatment Facility).</p> <p>Review on 04/05/18 of staff notes for client #3 revealed:</p> <ul style="list-style-type: none"> - Put in time out room, 3/20/18 . - Put in isolation environment, 3/24/18. - Put in time out room, 04/03/18. - Sent to time out room, 04/04/18. <p>Review on 04/09/18 of client #6's record revealed:</p> <ul style="list-style-type: none"> - 17 year old male. - Admission date of 03/17/18. - Diagnoses of Unspecified Schizophrenia Spectrum & Other Psychotic Disorders, Cyclothymic Disorder With Anxious Distress, ADHD, Intermittent Explosive Disorder, Other Specified Disruptive Mood Disorder, Impulse Control Disorder, Autism Disorder and Intellectual Development Disability, Moderate. - PCP dated 08/03/17 revealed, "He threatens to hurt mom's dog that she uses as a service dog and other family pets...history of twisting mom's arm...He needs constant supervision...lack of remorse, his behaviors scare her (mom). He stole his father's truck and wrecked it...impulsiveness...does not see the 	V 520		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 520	<p>Continued From page 90</p> <p>danger...cruelty to people or animals, often bullies, threatens intimidates others, frequent lying...collaborate with therapist. Therapist will facilitate group with [client #6] and peers in order to increase positive communication and problem solving skills...his recent behaviors requires a locked setting...level IV residential treatment, 24 hours a day, 7 days a week..."</p> <p>Review on 04/05/18 of DHSR (Division of Health Service Regulation) records revealed the facility was not licensed/approved for a time out room at initial licensure on November 1, 2017.</p> <p>Observation and interview on 04/05/18 at approximately 10:00 am while the walk through of the facility was conducted with the Operations Manager/Group Home Manager revealed:</p> <ul style="list-style-type: none"> -The Operations Manager/Group Home Manager identified the room as the time out room, which was not in use at the facility. - A small room on the bedroom hallway with a window in the door and deadbolt and no handle to enter/exit the room. - A client's personal items, a ball and slippers were on the floor of the time out room. - The floor space/dimensions of the room was undetermined. <p>Interview on 04/05/18 client #3 stated:</p> <ul style="list-style-type: none"> - He was often placed in the time out room by the staff. - "Last week (03/25/18 - 03/31/18, exact date could not be determined), [staff #2] put me in the time out room. - "I just smeared do-do all over the time out walls and the window. - I was spelling cuss words with do-do, 'cause I was acting up and staff locked the door and go away, 15-20-30 minutes; it doesn't matter if you 	V 520		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 520	<p>Continued From page 91</p> <p>do something bad like kicking the door then you get more time. - The door is made for kicking, can't bust it."</p> <p>Interview on 04/05/18 client #6 stated: -He had been placed in the time out room by the staff. -"You go to the time out room, 'cause not behaving. - Staff said I had a bad attitude...[staff #9] sent me to the time out room and the door is locked when you go in with the key. -They don't want anyone to bother us in there, so they lock it with a key. -[Client #3] goes in time out room all the time and he's a little kid."</p> <p>Interview on 04/05/18 client #4 stated: - He has not been in the time out room; He "tries to stay out of there." - [Client #3] goes in time out room the most; [client #6] one or two times. - [Client #3] in the time out room sorta on a daily thing; can't seem to stay out of time out room. - [Client #3] absolutely bad, hurting people, way out, steals stuff. -A couple of weeks ago he smeared, you know #2 (feces) everywhere in the time out room. -He had to clean it up by himself."</p> <p>Interview on 04/05/18 client #7 stated: -He has not been in the time out room, "just [client #3]." - "He fakes crying and just sits in time out room crying, cussing and calling people the 'n' word, foul mouth. -Sometimes he goes in 2 times a day."</p> <p>Interview on 04/05/18 staff #3 stated: -She has not used the time out room at the</p>	V 520		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 520	<p>Continued From page 92</p> <p>facility.</p> <p>- "I would (use the time out room) if they were causing harm to self or others."</p> <p>Interview on 04/05/18 staff #2 stated:</p> <p>- The time out room is not utilized at all.</p> <p>- "I use it (time out room) as a deterrent, I say man you could go in there, but I don't put anyone in there."</p> <p>Interview on 04/12/18 staff #6 stated:</p> <p>- "I put one client in time out room, [client #3] and maybe [client #6].</p> <p>- Nobody ever told us how to use the time out room."</p> <p>Interview on 04/09/18 staff #9 stated:</p> <p>- "[Client #3] was in time out room cleaning up feces in the time out room when I came in (date undetermined) feces all over the floor and walls, not sure who had put him in the time out room."</p> <p>- "I placed [client #6] in the time out room (specific date unknown - 03/2018).</p> <p>- One staff allowed him to have a cell phone, iPhone or something like that.</p> <p>- I told him he couldn't have it...he got combative on me and I put him in a therapeutic hold and walked him to time out room to calm down for 10-15 minutes..."</p> <p>Interview on 04/09/18 staff #10 stated:</p> <p>- "The lock up room (time out room) is to be used if any problems, (with the clients).</p> <p>- Room is not padded.</p> <p>- I had to put [client #3] in the time out room 03/31/18, he walked and the door was locked.</p> <p>- [Staff #4] said to lock them (clients) in the quiet room if they needed it or needed to be taken down (therapeutic hold).</p> <p>- No one trained me on take downs or how to use</p>	V 520		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 520	Continued From page 93 the quiet room for the time outs." Interview on 04/05/18, 04/09/18 and 04/10/18 the Licensee stated: -The time out room was not in use at the facility. -She had given staff instructions not to use the time out room. This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (V513) for a Type A1 rule violation.	V 520		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention;	V 521		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 521	<p>Continued From page 94</p> <p>(F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;</p> <p>(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and</p> <p>(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control to include documentation, notation of client's physical and psychological well-being, rational for use and description of the intervention, debriefing and planning, affecting 2 of 7 clients (#3, #6).</p> <p>Refer to tag V520 for specific details.</p> <p>Review on 04/09/18 of client #3 and #6's records revealed: -No evidence of documentation of all times the time out room was utilized for behavioral control, no notation of the client's physical and psychological well being and rational for use and description of the intervention, debriefing and planning.</p> <p>Interviews on 04/05/18 through 04/12/18 the audited facility staff stated they had used the time out room for negative behaviors or would use the time out room if needed and had not documented</p>	V 521	<p>V521: Measures in place to correct the deficiency:</p> <p>1.NCI (alternative to restrictive interventions) training was provided for the staff again, emphasizing that time-out and isolation would not be used. See training certificates</p> <p>2.The staff will be trained on the New Horizon Restrictive Intervention Policy reflecting no use of isolation or use of time-out.</p> <p>3.Client Rights training was provided to the staff. See training certificate</p> <p>4.Re-designed the room that had been wrongly used as a time-out room. The room has been re-designed as a study area with computers for the consumers use.</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.Continued monitoring and shadowing of the staff to provide immediate feedback regarding appropriate behavior modifications.</p> <p>2.Follow-up any issues in staff meetings and/or individual supervisions, as warranted.</p> <p>3.Place additional staff on shift to assist with meeting the behavioral needs of the consumer, if warranted.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Quality Management Director Qualified Professional</p>	<p>4-14-18</p> <p>Prior to 5-12-18</p> <p>4-21-18</p> <p>Completed prior to 4-30-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 521	Continued From page 95 the use of the time out room. All staff stated they had not been trained in the rationale for use or the debriefing and planning with any legal guardian when the time out room was used. This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (V513) for a Type A1 rule violation.	V 521		
V 522	27E .0104(e10) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (10) The emergency use of restrictive interventions shall be limited, as follows: (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization; (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training; (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but	V 522		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 522	<p>Continued From page 96</p> <p>concur that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made;</p> <p>(D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and</p> <p>(E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to maintain a time-out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions as an emergency use of a restrictive intervention, approved staff to administer intervention, conduct assessment which includes the physical and psychological well-being of the client and obtain a written order for time-out affecting 2 of 7 clients (#3, #6). The findings are:</p> <p>Refer to tag V520 for specific details.</p> <p>Interviews on 04/05/18 through 04/12/18 the audited facility staff stated they had used the time out room for negative behaviors or would use the time out room if needed. All staff reported they had not been trained on the use of the time out room including no training on receiving authorization for use of the time out procedures.</p>	V 522	<p>V522: Measures in place to correct the deficiency:</p> <p>1.NCI (alternative to restrictive intervention) training was provided for the staff again emphasizing that time-out and isolation would not be used. See training certificates</p> <p>2.The staff will be trained on the New Horizon Restrictive Intervention Policy reflecting no use of isolation or use of time-out.</p> <p>3.Client Rights training was provided to the staff. See training certificate</p> <p>4.Re-designed the room that had been wrongly used as a time-out room. The room has been re-designed as a study area with computers for the consumers use.</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.Continued monitoring and shadowing of the staff to provide immediate feedback regarding appropriate behavior modifications.</p> <p>2.Follow-up any issues in staff meetings and/or individual supervisions, as warranted.</p> <p>3.Place additional staff per shift, depending on the needs of the consumer.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Quality Management Director Qualified Professional</p>	<p>4-14-18</p> <p>Prior to 5-12-18</p> <p>4-21-18</p> <p>Completed prior to 4-30-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 522	Continued From page 97 Review on 04/05/18 through 04/12/18 of client #3 and client #6's records revealed no documentation of authorization given for the use of time out procedures. Review on 04/05/18 of facility records revealed facility had no Qualified Professional (QP) or Licensed Professional (LP) to monitor and authorize use of restrictive interventions. Interview on 04/05/18 the Licensee stated she had instructed the staff not to use the time out room and was unaware staff had used the time out room for behavior control for client #3 and client #6. The Licensee reported she currently had no QP or LP employed at the facility. This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (V513) for a Type A1 rule violation.	V 522		
V 523	27E .0104(e11) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (11) The following precautions and actions shall be employed whenever a client is in: (A) seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the client shall occur at least every 15 minutes, or more often as	V 523		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 523	<p>Continued From page 98</p> <p>necessary, to assure the safety of the client, attention shall be paid to the provision of regular meals, bathing and the use of the toilet; and such observation and attention shall be documented in the client record;</p> <p>(B) isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out; there shall be continuous observation and verbal interaction with the client when appropriate; and such observation shall be documented in the client record; and</p> <p>(C) physical restraint and may be subject to injury: a facility employee shall remain present with the client continuously.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include periodic observation of at least every 15 minutes, provision to the use of the toilet, documentation in the client record and a facility staff with no other immediate responsibility other than to monitor client who is placed in time, provide continuous observation and verbal interaction affecting 2 of 7 clients (#3, #6). The findings are:</p> <p>Refer to tag V520 for specific details.</p> <p>Review on 04/09/18 of client #3 and #6's records revealed: -No documentation of observation by staff when the time out room was used for behavioral control.</p>	V 523	<p>V523: Measures in place to correct the deficiency:</p> <p>1.NCI, alternative to restrictive intervention, training was provided for the staff again emphasizing that time-out and isolation would not be used. See training certificates 4-14-18</p> <p>2.The staff will be trained on the New Horizon Restrictive Intervention Policy reflecting no use of isolation or use of time-out. Prior to 5-12-18</p> <p>3.Client Rights training was provided to the staff. See training certificate 4-21-18</p> <p>4.Re-designed the room that had been wrongly used as a time-out room. The room has been re-designed as a study area with computers for the consumers use. Completed prior to 4-30-18</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.Continued monitoring and shadowing of the staff to provide immediate feedback regarding appropriate behavior modifications. Ongoing</p> <p>2.Follow-up any issues in staff meetings and/or individual supervisions, as warranted. Ongoing</p> <p>3.Place additional staff per shift, depending on the needs of the consumer. Ongoing</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Quality Management Director Qualified Professional Ongoing</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 523	Continued From page 99 Staff interviews from 04/05/18 through 04/11/18 revealed no staff had been trained in the use of restrictive interventions including use of a time out room and the specific requirements for such. Interview on 04/05/18 the Licensee stated she was unaware staff had used the time out room for behavior control for client #3 and client #6. This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (V513) for a Type A1 rule violation.	V 523		
V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule.	V 524		

Division of Health Service Regulation

<p>V 524</p>	<p>Continued From page 100</p> <p>(14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout.</p> <p>(15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions.</p> <p>(16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows:</p> <p>(A) those to be notified as soon as possible but within 24 hours of the next working day, to include:</p> <p>(i) the treatment or habilitation team, or its designee, after each use of the intervention; and</p> <p>(ii) a designee of the governing body; and</p> <p>(B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include the required documentation, required notification, an order for the use of the restrictive intervention and the written approval of the designee of the governing body, affecting 2 of 7 clients (#3, #6). The findings are:</p> <p>Refer to tag V520 for specific details.</p> <p>Review on 04/09/18 of client #3 and #6's records revealed:</p>	<p>V 524</p>	<p>V524: Measures in place to correct the deficiency:</p> <p>1.NCI, alternative to restrictive intervention, training was provided for the staff again emphasizing that time-out and isolation would not be used. See training certificates</p> <p>2.The staff will be trained on the New Horizon Restrictive Intervention Policy reflecting no use of isolation or use of time-out. It also reflects the circumstances under which a restrictive intervention can be used i.e., restrictive hold.</p> <p>3.Client Rights training was provided to the staff. See training certificate</p> <p>4.Re-designed the room that had been wrongly used as a time-out room. The room has been re-designed as a study area with computers for the consumers use.</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.Continued monitoring and shadowing of the staff to provide immediate feedback regarding appropriate behavior modifications.</p> <p>2.Follow-up any issues in staff meetings and/or individual supervisions, as warranted.</p> <p>3.Place additional staff per shift, depending on the needs of the consumer.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Quality Management Director Qualified Professional</p>	<p>4-14-18</p> <p>Prior to 5-12-18</p> <p>4-21-18</p> <p>Completed prior to 4-30-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
--------------	--	--------------	---	---

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 524	Continued From page 101 -No required documentation of the use of the time out room including an order for the use of such. Review on 04/05/18 - 04/13/18 of facility records revealed no documentation of notification to required persons including the treatment team, designee of the governing body nor the legally responsible person. Interviews on 04/05/18 through 04/12/18 the audited facility staff stated they had used the time out room for negative client behaviors. All staff reported they had no training in the use of restrictive interventions including the use of time out procedures. Staff reported they did not provide continuous monitoring for clients while in the time out room. This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (V513) for a Type A1 rule violation.	V 524		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A;	V 525		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE LUMBER BRIDGE, NC 28357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 525	<p>Continued From page 102</p> <p>(B) an investigation of any unusual or possibly unwarranted patterns of utilization; and</p> <p>(C) documentation of the following shall be maintained on a log:</p> <ul style="list-style-type: none"> (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include, reviews and reports of any and all restrictive interventions, a regular review by a designee and by the Client Rights Committee and an investigation of any unusual or possible unwarranted patterns of use and documentation log with required information, positive and less restrictive alternatives used or considered and debriefing and planning with the required persons and the negative effects of the restrictive intervention and any impact on the</p>	V 525	<p>V525:</p> <p>Measures in place to correct the deficiency:</p> <p>1.NCI, alternative to restrictive intervention, training was provided for the staff again emphasizing that time-out and isolation would not be used. See training certificates</p> <p>2.The staff will be trained on the New Horizon Restrictive Intervention Policy reflecting no use of isolation or use of time-out. It also reflects the circumstances under which a restrictive intervention can be used i.e., restrictive hold.</p> <p>3.Client Rights training was provided to the staff. See training certificate</p> <p>4.Re-designed the room that had been wrongly used as a time-out room. The room has been re-designed as a study area with computers for the consumers use.</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.Continued monitoring and shadowing of the staff to provide immediate feedback regarding appropriate behavior modifications. LPC, QP, Psychiatrist are in place to assist staff with addressing the behavioral needs of the consumer(s).</p> <p>2.Follow-up any issues in staff meetings and/or individual supervisions, as warranted.</p> <p>3.Place additional staff per shift, depending on the needs of the consumer.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Quality Management Director Qualified Professional</p>	<p>4-14-18</p> <p>Prior to 5-12-18</p> <p>4-21-18</p> <p>Completed prior to 4-30-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 525	Continued From page 103 physical and psychological well-being of the client affecting 2 of 7 clients (#3, #6). The findings are: Refer to tag V520 for specific details. Review on 04/09/18 through 04/13/18 of facility records and client records revealed no documentation the use of the time out room was reported to the necessary persons including a Client Rights Committee. Review further revealed no documentaiton reviews were conducted on the use of time out procedures for client #3 and client #6. No documenten was available indicating debriefing and planning was conducted as required. There was no documentation of the physical and psychological well-being of the clients. Interviews on 04/05/18 through 04/12/18 the audited facility staff stated they had used the time out room for negative client behaviors. All staff reported they had received no training in the use of restrictive itnerventions including use of a time out room. This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (V513) for a Type A1 rule violation.	V 525		
V 526	27E .0104(e18-19) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL	V 526		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 526	Continued From page 104 (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident: (A) the type of procedure used and the length of time employed; (B) alternatives considered or employed; and (C) the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. (19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to maintain a time out/isolation room used for behavioral control in a safe and harmfree manner and according to the required policy and procedures and the required provisions to include, failed to collect and analyzing data on the use of the restrictive intervention, document the type of procedure used and length of time employed, document alternatives considered and effectiveness, affecting 2 of 7 clients (#3, #6). The findings are: Refer to tag V520 for specific details. Review on 04/09/18 of facility records and client	V 526	V526: Measures in place to correct the deficiency: 1.NCI, alternative to restrictive intervention, training was provided for the staff again emphasizing that time-out and isolation would not be used. See training certificates 2.The staff will be trained on the New Horizon Restrictive Intervention Policy reflecting no use of isolation or use of time-out. It also reflects the circumstances under which a restrictive intervention can be used i.e., restrictive hold. 3.Client Rights training was provided to the staff. See training certificate 4.Re-designed the room that had been wrongly used as a time-out room. The room has been re-designed as a study area with computers for the consumers use. Measures in place to prevent reoccurrence of the problem: 1.Continued monitoring and shadowing of the staff to provide immediate feedback regarding appropriate behavior modifications. LPC, QP, Psychiatrist are in place to assist staff with addressing the behavioral needs of the consumer(s). 2.Follow-up any issues in staff meetings and/or individual supervisions, as warranted. 3.Place additional staff per shift, depending on the needs of the consumer. Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Quality Management Director Qualified Professional	4-14-18 Prior to 5-12-18 4-21-18 Completed prior to 4-30-18 Ongoing Ongoing Ongoing Ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 526	Continued From page 105 records revealed no documentation that data had been collected and analyzed to monitor and determine the effectiveness of such procedures. Interviews on 04/05/18 through 04/12/18 the audited facility staff stated they had used the time out room for negative client behaviors. All staff reported they had received no training in the use of restrictive interventions including use of time out procedures. This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (V513) for a Type A1 rule violation.	V 526		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives,	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 106 measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 107 at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE <div style="background-color: black; height: 15px; width: 100%;"></div> LUMBER BRIDGE, NC 28357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 108</p> <p>review by the coach.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure six of six audited staff (#2, #3, #6, #9, #10, and the Operations Manager/Group Home Manager) received initial training in alternatives to restrictive interventions. The findings are:</p>	V 536	<p>V536:</p> <p>Measures in place to correct the deficiency:</p> <p>1.NCI, alternative to restrictive interventions, has been provided to the staff by a certified instructor using an approved curriculum. See training certificates and trainer's credentials</p> <p>Measures in place to prevent reoccurrence of the problem:</p> <p>1.New Horizon Group Home maintains a data base of all required training and due dates. The CEO is given a list of needed training events at least one month in advance of the due date.</p> <p>Who is monitoring and how often to ensure the problem will not re-occur:</p> <p>Quality Management Director</p>	<p>4-14-18</p> <p>Ongoing</p> <p>Ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 109</p> <p>Review on 04/10/18 of the Approved Curricula for the Use of De-Escalation Strategies and Restrictive Effective January 22, 2018 revealed: -The trainer identified on all the staffs' training certificates was not listed as an approved trainer/instructor.</p> <p>Review on 04/10/18 of Staff #3's personnel file revealed: -Date of application on 02/20/18. -North Carolina Interventions (NCI) training in alternatives to restrictive interventions training certificate dated 02/17/18.</p> <p>Interview on 04/05/18 staff #3 stated: -She did not remember the trainers/instructors.</p> <p>Review on 04/10/18 of Staff #2's personnel file revealed: -Date of application on 02/20/18. -NCI training in alternatives to restrictive interventions training certificate dated 02/17/18.</p> <p>Interview on 04/05/18 staff #2 stated: -He did not remember the trainer/instructor.</p> <p>Review on 04/10/18 of staff #6's record revealed: - Date of application: 02/17/18. - NCI training in alternatives to restrictive interventions training certificate dated 02/17/18.</p> <p>Interview on 04/12/18 staff #6 stated: -She had received no NCI training in alternatives to restrictive interventions, "never."</p> <p>Review on 04/10/18 of staff #9's record revealed: - Date of application: 02/02/18. -NCI training in alternatives to restrictive interventions training certificate dated 02/17/18.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 110</p> <p>Interview on 04/09/18 staff #9 stated: - "All my trainings were on the job, no NCI."</p> <p>Review on 04/10/18 of staff #10's record revealed: - Date of application: 02/13/18. - NCI training in alternatives to restrictive interventions training certificate dated 02/17/18.</p> <p>Interview on 04/09/18 staff #10 stated: - He had not received any training in NCI; "no training at all, none."</p> <p>Review on 04/10/18 of the Operations Manager/Group Home Manager's personnel file revealed: - Date of application on 02/20/18. - NCI training in alternatives to restrictive interventions training certificate dated 02/17/18.</p> <p>Interview on 04/05/18 the Operation Manager/Group home manager stated: - He had only worked for one week at the facility. - He he had received NCI.</p> <p>Interview on 04/10/18 the Licensee stated: - She was aware staff should have the required training. - She had paid for NCI training. - She was unsure why staff would say they had not been trained. - She did not have contact information available for the trainer.</p> <p>This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE Tag V513 of reviewed deficiencies for a Type A1 rule violation.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	<p>Continued From page 111</p> <p>27E .0108 Client Rights - Training in Sec Rest & ITO</p> <p>10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT</p> <p>(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.</p> <p>(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.</p> <p>(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	<p>Continued From page 112</p> <p>Paragraph (g) of this Rule.</p> <p>(g) Acceptable training programs shall include, but are not limited to, presentation of:</p> <p>(1) refresher information on alternatives to the use of restrictive interventions;</p> <p>(2) guidelines on when to intervene (understanding imminent danger to self and others);</p> <p>(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);</p> <p>(4) strategies for the safe implementation of restrictive interventions;</p> <p>(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;</p> <p>(6) prohibited procedures;</p> <p>(7) debriefing strategies, including their importance and purpose; and</p> <p>(8) documentation methods/procedures.</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualification and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	<p>Continued From page 113</p> <p>need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.</p> <p>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.</p> <p>(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) evaluation of trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.</p> <p>(8) Trainers shall be currently trained in CPR.</p> <p>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.</p> <p>(10) Trainers shall teach a program on the use of restrictive interventions at least once</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	Continued From page 114 annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure six of six audited staff (#2, #3, #6, #9, #10 and the Operations Manager/Group Home Manager) received training in seclusion, physical restraint and isolation time-out only by staff who have been trained and demonstrated competence and prior to providing direct care to people with disabilities. The findings are: Review on 04/10/18 of the Approved Curricula for the Use of De-Escalation Strategies and	V 537	V537: Measures in place to correct the deficiency: 1. New Horizon only implements restrictive interventions in the case of a situation that could result in bodily harm, per New Horizon Restrictive Intervention Policy. Training will be provided to the staff. 2. The room in question that was originally built as a time-out room when the building was built, was not intended to use as such by New Horizon's CEO. Since the survey, the room has been re-designed by removing the door, placing a table with computers for the consumer's use for academics and/or activity. Measures in place to prevent reoccurrence of the problem: 1. The "room" has been re-designed and equipped for the consumers with academics and activities. 2. Licensed staff in place to assist the direct care staff with behavioral health needs of the consumers. 3. New Horizon's ability to add additional staff to a shift to assist with behavior management. Who is monitoring and how often to ensure the problem will not re-occur: Clinical Director/LPC Qualified Professional	Prior to 5-12-18 Completed prior to 4-30-18 Completed prior to 4-30-18 4-25-18 4-28-18 Ongoing Ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	<p>Continued From page 115</p> <p>Restrictive Effective January 22, 2018 revealed: -The trainer identified on all the staffs' training certificates was not listed as an approved trainer/instructor.</p> <p>Review on 04/10/18 of Staff #3's personnel file revealed: -Date of application on 02/20/18. -North Carolina Interventions (NCI) training in seclusion, physical restraint and isolation time-out training certificate dated 02/17/18</p> <p>Interview on 04/05/18 staff #3 stated: -She did not remember the trainers/instructors.</p> <p>Review on 04/10/18 of Staff #2's personnel file revealed: -Date of application on 02/20/18. - NCI training in seclusion, physical restraint and isolation time-out training certificate dated 02/17/18</p> <p>Interview on 04/05/18 staff #2 stated: -He did not remember the trainer/instructor.</p> <p>Review on 04/10/18 of staff #6's record revealed: - Date of application: 02/17/18. - NCI training in seclusion, physical restraint and isolation time-out training certificate dated 02/17/18.</p> <p>Interview on 04/12/18 staff #6 stated: -She had received no NCI training, "never."</p> <p>Review on 04/10/18 of staff #9's record revealed: - Date of application: 02/02/18. -NCI training in seclusion, physical restraint and isolation time-out training certificate dated 02/17/18.</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	<p>Continued From page 116</p> <p>Interview on 04/09/18 staff #9 stated: - "All my trainings were on the job, no NCI."</p> <p>Review on 04/10/18 of staff #10's record revealed: - Date of application: 02/13/18. - NCI training in seclusion, physical restraint and isolation time-out training certificate dated 02/17/18.</p> <p>Interview on 04/09/18 staff #10 stated: - He had not received any training in NCI; "no training at all, none."</p> <p>Review on 04/10/18 of the Operations Manager/Group Home Manager's personnel file revealed: - Date of application on 02/20/18. - NCI training in seclusion, physical restraint and isolation time-out training certificate dated 02/17/18.</p> <p>Interview on 04/05/18 the Operation Manager/Group home manager stated: - He had only worked for one week at the facility. - He he had received NCI.</p> <p>Interview on 04/10/18 the Licensee stated: - She was aware staff should have the required training. - She had paid for NCI training. - She was unsure why staff would say they had not been trained. - She did not have contact information available for the trainer.</p> <p>This deficiency is crossed referenced into 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE Tag V513 of reviewed deficiencies for a Type A1 rule violation.</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

NEW HORIZON GROUP HOME, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 117 27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interview, the facility was not maintain in a clean and attractive manner. The findings are: Observations of the facility on 04/05/18 at 10:15 am revealed: -TV/Living area of the facility had two fabric sofas with tears on the cushions and the inner material visible. -TV/Living area of the facility had a leather like material and the material was frayed and peeling off the cushions and arm rests of the sofa. - Client #6 bedroom linens/pillow case had multiple darken blood-like stains. - Second bathroom tile floor on main bedroom hallway had a crack in the tile less than 2 feet in length. Interview on 04/05/18 the Licensee stated: -She would address the needed repairs in the facility.	V 736	V 736: Measures in place to correct the deficiency: 1.The two fabric sofas are being repaired or replaced. 2.The leather like material sofa is being repaired or replaced. 3.The "dark stain" on the pillowcase was from a nose bleed earlier that morning. All linens are fresh and have been replaced with extra linens in storage closet. 4.Some grout is being placed in the crack in tile. Measures in place to prevent reoccurrence of the problem: 1.A monthly "Safety Review" walk through will be completed at least one time per month by the Group Home Manager and/or Qualified Professional. Completed form will be forwarded to the Corporate Office to be reviewed by the Quality Management Director. 2.An independent Safety Review will be completed every 6-months by a non-employee. Report will be given to the CEO. See copy of the Safety Checklist Who is monitoring and how often to ensure the problem will not re-occur: Group Home Manager Qualified Management Director Qualified Professional Independent Consultant for Safety Review	5-12-18 5-12-18 5-12-18 5-12-18 Monthly and ongoing Every 6-months
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum	V 774		Ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
NAME OF PROVIDER OR SUPPLIER NEW HORIZON GROUP HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE LUMBER BRIDGE, NC 28357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 774	<p>Continued From page 118</p> <p>square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to provided minimum furnishings for client bedrooms. The findings are:</p> <p>Review on 04/05/18 of the DHSR (Division Of Health Service Regulation) license effective on 11/01/17 revealed the facility was licensed for capacity of 9 clients.</p> <p>Observation in the facility on 04/05/18 at 10:50 am revealed: - Seven clients were residing at the facility. - There were no bedside tables in any of the bedrooms. - The only storage the clients had were small shared closets for clients' personal clothing and personal items and a metal hanging closet with wheels for client #7's room.</p> <p>During interview on 04/05/18 the Licensee stated: - She was not aware she needed to have bedside tables in each of the clients' bedrooms.</p>	V 774	<p>V 774:</p> <p>Measures in place to correct the deficiency: 1. Bedside tables, storage bins, and computer tables have been placed in each of the bedrooms.</p> <p>Measures in place to prevent reoccurrence of the problem: 1. A monthly "Safety Review" walk through will be completed at least one time per month by the Group Home Manager and/or Qualified Professional. Completed form will be forwarded to the Corporate Office to be reviewed by the Quality Management Director.</p> <p>2. An independent Safety Review will be completed every 6-months by a non-employee. Report will be given to the CEO. See copy of the Safety Checklist</p> <p>Who is monitoring and how often to ensure the problem will not re-occur: Group Home Manager Qualified Management Director Qualified Professional Independent Consultant for Safety Review</p>	<p>Completed prior to 5-04-18</p> <p>Monthly and ongoing</p> <p>Every 6-months</p> <p>Ongoing</p>

Confirmation for Disaster Drills:

The Group Home QP and/or Group Home Manager is responsible for implementing the disaster and fire drills at the group home. Drills of emergency procedures are conducted at least quarterly during varying times of operation in the group home and reflect realistic events. Group home drills must be completed at least monthly and during both day and night shifts. By the end of the quarter, a fire drill and a disaster drill should have been completed on each of the shifts. Information including the date and time of the tests, number of persons involved, time involved in the tests, and assessment of the process is documented by the QP. A copy of the disaster drills and fire drills will be forwarded to the Corporate Office for review. The drill is held with no person served knowing that it is about to happen.

Use the Emergency Operation Plan to see how to carry out each of the drills.

A copy of the drill shall be forwarded to the Corporate Office upon completion. The original drill form and this Confirmation Form shall be maintained at the Group Home location.

Quarter 1	Complete one of these per month; one on each shift for the month	Complete one type of disaster drill from this list per month.			
	Fire	Hazardous Materials	Severe Weather: Hurricane, Tornado	Threat of Violence or Harm: Bomb Threat	Utility Power or Mechanical Failure
January					
February					
March					
Quarter 2	Complete one of these per month; one on each shift for the month	Complete one type of disaster drill from this list per month.			
	Fire	Hazardous Materials	Severe Weather: Hurricane, Tornado	Threat of Violence or Harm: Bomb Threat	Utility Power or Mechanical Failure
April					
May					
June					

Quarter 3	Complete one of these per month; one on each shift for the month	Complete one type of disaster drill from this list per month.			
	Fire	Hazardous Materials	Severe Weather: Hurricane, Tornado	Threat of Violence or Harm: Bomb Threat	Utility Power or Mechanical Failure
July					
August					
September					
Quarter 4	Complete one of these per month; one on each shift for the month	Complete one type of disaster drill from this list per month.			
	Fire	Hazardous Materials	Severe Weather: Hurricane, Tornado	Threat of Violence or Harm: Bomb Threat	Utility Power or Mechanical Failure
October					
November					
December					

New Horizons, LLC	Policy No.: C-14 Page 1 of 5
Subject: Incident Reports	Effective Date: 01/01/09
	Revised Date: 05/03/18

Policy

New Horizons, LLC immediately reports all incidents or unusual occurrences.

Procedures

1. The Director ensures that Level I, II or III incidents are responded to by assigning staff directly involved with the consumer and the Qualified Professional to:
 - a. Immediately attend to the health and safety needs of consumers involved in the incident;
 - b. Determine the cause of the incident;
 - c. Develop and implement corrective measures;
 - d. Develop and implement measures to prevent similar incidents, which will be monitored by the Human Rights Committee;
 - e. Be responsible for implementation of the corrections and preventative measures; and
 - f. Maintain documentation of a-e above.
2. The Director responds to any Level III incident that occurs while a consumer is in New Horizons, LLC care or on its premises by immediately securing the consumer's record by:
 - a. Obtaining the consumer's record;
 - b. Making a photocopy;
 - c. Certifying the copy's completeness; and
 - d. Transferring the copy to a peer review team.
3. The Director if designated appoints a peer review team to convene within 24 hours of the incident. The peer review team:
 - a. Reviews the copy of the consumer's record;
 - b. Gathers other information needed;
 - c. Issues a report concerning the incident to the Director and to the consumer's home area authority/LME to facilitate the monitoring of services as required by G.S. 122C-111 and other State statutes; and
 - d. Immediately notifies the following:
 - The local area authority/LME;
 - The consumer's legal guardian, as applicable; and
 - Any other authorities required by law.
4. The Director assures that Level II or Level III incidents are reported to the local area authority/LME within 72 hours of the incident. The report is

New Horizons, LLC	Policy No.: C-14 Page 2 of 5
Subject: Incident Reports	Effective Date: 01/01/09
	Revised Date: 05/03/18

submitted on the DHHS Incident and Death Reporting Form approved by the Secretary of the Department of Health and Human Services (DHHS). The report may be submitted via mail, in person, facsimile or other electronic means. The report includes the following information:

- a. New Horizons, LLC contact person and identification information;
 - b. Consumer's identification information;
 - c. Type of incident;
 - d. Description of incident;
 - e. Status of the effort to determine the cause of the incident; and
 - f. Other individuals or authorities notified or responding.
5. Any missing or incomplete information is explained and by the end of the next business day, the Director ensures that staff update the report by:
 - a. Notifying the local area authority/LME when it has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; and
 - b. Submitting to the local area authority/LME information required on the incident form that was previously unavailable.
6. The Director or designee submits, upon request by the local authority/LME and proper consent of the consumer or legally responsible person, other information obtained regarding the incident, including:
 - a. Hospital records including confidential information;
 - b. Reports by other authorities; and
 - c. New Horizons, LLC response to the incident.
7. The Director designates an employee who is responsible for sending a quarterly report to the local area authority/LME on a form provided by the Secretary of DHHS, via electronic means. The report includes summary information as follows:
 - a. Medication errors that do not meet the definition of a Level I or Level II incident;
 - b. Searches of a consumer or his/her living area; and
 - c. Seizures of consumer's property or property in the possession of a consumer.
8. The Director assures that a copy of all Level III incident report is provided DMH/DD/SAS and/or DHRS for Category A providers and DMH/DD/SAS for Category B providers immediately upon receipt of the report.

New Horizons, LLC	Policy No.: C-14 Page 3 of 5
Subject: Incident Reports	Effective Date: 01/01/09
	Revised Date: 05/03/18

9. All incidents/accidents are reported to the Director, as soon as possible, and no later than (1) hour of the incident becoming known.
 - a. An employee completes and submits the reporting form within 24 hours to the Director or designee who reviews, signs, files the form and initiates any necessary action.
 - b. The Director or designee verbally reports all incidents to the County Program/LME, as appropriate, within that 24-hour period and provides a copy of the form within 72 hours. If the incident is over a weekend or holiday, the form must reach the Program/LME at the beginning of the next work day.
10. The Director reviews each incident and takes any additional corrective actions, as indicated, to prevent future occurrence of similar incidents.
11. Examples of incident/accident reports for documentation include, but are not limited to:
 - a. Any accident or injury, including self-injurious behavior, which requires treatment by a physician. First aid provided by a nurse or other facility staff would not be included in this category;
 - b. Any medication error, including lack of administration of a prescribed medication, which causes the consumer discomfort or places his or her health or safety in jeopardy;
 - c. Use of any hazardous substance which requires treatment by a physician. First aid provided by a nurse or other facility staff would not be included in this category;
 - d. A consumer's elopement (escape, run away from or abscond) lasting more than 3 hours;
 - e. A consumer's death;
 - f. Suspension or expulsion of a consumer from services or supports;
 - g. Any case of abuse, neglect or exploitation against a consumer which is under investigation or has been substantiated by a county Department of Social Services (DSS) or the DHRS Health Care Personnel Registry Section;
 - h. Any suicide attempt which results in injury or places the consumer in jeopardy;
 - i. The arrest of a consumer for violations of state, municipal, county, or federal law; or
 - j. Any fire or equipment failure that places the health or safety of a consumer in jeopardy.

New Horizons, LLC	Policy No.: C-14 Page 4 of 5
Subject: Incident Reports	Effective Date: 01/01/09
	Revised Date: 05/03/18

12. Reporting of incidents and unusual occurrences includes:
 - a. a description of the event;
 - b. actions taken on behalf of the consumer (corrective actions taken); and
 - c. the consumer's condition following the event.

- 12.If the incident involved any suspicion of abuse, neglect or exploitation of a consumer, the staff witnessing the event or suspecting such must report it to the county Department of Social Services and a Health Care Registry report completed within 24 hours.

- 13.Incident Reports which include the administrative review must not be referenced or filed in the consumer record but filed in administrative files. Opinions, conclusions, or personnel actions relative to the event must not be included in the consumer's record. The occurrence of an incident is recorded in the service record.

- 14.The Quality Improvement Committee reviews aggregate reporting of incidents and unusual occurrences. The Director reviews each incident and takes any additional corrective actions, as indicated, to prevent future occurrence of similar incidents.

- 15.Incidents that are not routinely reported to DMH/DD/SAS or DHSR include: communicable diseases, infection control, vehicular accidents, biohazardous accidents, and unauthorized use or possession of licit or illicit substances. These incidents should be documented on the DHHS Incident Reporting form and given to the Director immediately upon an occurrence. The Director takes the proper action of reporting, if necessary.
 1. Communicable disease are reported to the person's private physician and/or Public Health Department
 2. Infection control are reported to OSHA, Public Health, private physician and others, as appropriate
 3. Vehicular accidents are reported to law enforcement and insurance carrier. When person served are in the vehicle, legal guardians are notified and the DHHS Incident Report is completed.
 4. Biohazardous accidents are reported to OSHA, private physician and others, as appropriate.
 5. Unauthorized use or possession of licit or illicit substances by staff results in disciplinary action, the severity depending upon the circumstance as determined by the Director. Illicit substances are referred to the public law enforcement agency and staff dismissed.

New Horizons, LLC	Policy No.: C-14 Page 5 of 5
Subject: Incident Reports	Effective Date: 01/01/09
	Revised Date: 05/03/18

6. Unauthorized use or possession of licit or illicit substances by persons served result in action, the severity depending upon the circumstance as determined by the treatment team and Director. Illicit substances are referred to the public law enforcement agency and staff dismissed.

16. Following any critical incident, staff debriefs with the people involved and documents the findings. Referrals are made for more intensive follow up/treatment, if indicated.

State Definitions

“Incidents” means any happening which is not consistent with the routine operation of a facility or service or the routine care of a consumer and that is likely to lead to adverse effects upon a consumer. [10 NCAC 27G .0103(b)(32)]

10 NACA 27G .0602 (5-7) includes:

- Level I incident – does not meet the definition of a level II incident or a level III incident.
- Level II incident – results in a threat to consumer’s health, safety; or a threat to the health, safety of others due to consumer behavior and does not meet definition of a Level III incident.
- Level III incident – results in: (a) a death, permanent physical or psychological impairment to a consumer; (b) a death, permanent physical or psychological impairment caused by a consumer; or (c) a threat to public safety caused by a consumer.

“Provider category” means the type of facility in which a consumer receives services or resides. The provider category determines the extent of monitoring that a provider receives and is determined as follows: Category A – facilities licensed pursuant to GS 122 C, Article 2. Category B – G.S. 122C, Article 2, community based providers not requiring State licensure. [10 NCAC 27G .0602 (10)]

Standard of Operation: Incident Reporting

Purpose: Outline of the steps needed in reporting an incident regarding scenarios constituting the need for a report, timelines for submission, and follow-up.

Internal Steps for reporting oversight:

- 1. CEO is notified by the staff person(s) involved in the incident and/or the Director or Manager of the service immediately;**
- 2. Operations Director will notify the Quality Management Director and Compliance staff person via email immediately upon notification of the incident;**
- 3. Operations Director will forward the passcodes for the incident, via email, to the above two staff immediately once the incident report has been entered into the IRIS System; and**
- 4. Quality Management Director and Compliance staff person will review the incident in the IRIS System for details and to ensure quality of care was adhered; and**
- 5. Quality Management Director will log the incident report onto the electronic Incident Report Log at which time all timelines are ensured to be within requirements.**

What is an incident?

Per DMH Incident Manual, an “incident”, is any happening which is not consistent with the routine operation of a facility or service or the routine care of a consumer and that is likely to lead to adverse effects upon a consumer. All Category A and B providers are required to report any adverse event that is not consistent with the routine operation of a facility or service or the routine care of a consumer.

Under Your Care:

- The definition for “a consumer under the care of a provider” refers to a consumer who has received any service in the 90 days prior to the incident.**
- Reporting of incidents is required for purposes of communication and timely response. Individuals receiving Residential or Assertive Community Treatment Team (ACTT) services are considered under the provider’s care 24 hours a day. Individuals receiving day services or periodic services are considered under the provider’s care while a staff person is providing services or if the consumer received any services from the provider in the 90 days prior to the incident.**

Standard of Operation: Incident Reporting

When to File?

Type of Incident	Report to Host LME	Report to Home LME	Report to DMH/DD/SAS (all providers)	Report to DHSR Complaint Intake Unit (122C-Licensed providers only)
Level II incident (including death from natural causes or terminal illness)	IRIS report within 72 hours	If required by contract	No report except for Opioid providers	No report
Level III incident (other than death)	Verbal report immediately IRIS report within 72 hours	Verbal report immediately IRIS report within 72 hours	IRIS report within 72 hours	No report
Death from suicide, accident, homicide, other violence	Verbal report immediately IRIS report within 72 hours	Verbal report immediately IRIS report within 72 hours	IRIS report within 72 hours	IRIS report within 72 hours
Death from unknown cause	Verbal report immediately IRIS report within 72 hours	Verbal report immediately IRIS report within 72 hours	IRIS report within 72 hours	No report
Death within 7 days of seclusion or restraint	IRIS report immediately	IRIS report immediately	IRIS report immediately	IRIS report immediately

A provider must submit an initial incident report within 72 hours of learning about an incident (this includes any incident occurring on site or while the consumer is on therapeutic leave relevant to residential services), even if the provider does not have all of the facts about an incident. This report should contain all of the information that the provider knows at the time of submission. When provider obtains or is informed about new or additional

Standard of Operation: Incident Reporting

information related to the incident, the provider must update the original report and submit the update information by the end of the next business day after becoming aware of the information. If the cause of death is initially unknown and later determined to be a result of suicide, accident, homicide, or other violence or occurs within 7 days of seclusion or restraint, file a Level III incident/death report within 72 hours of receiving the additional information on the cause of death.

The provider must submit the updated report even if the new information does not change the level

of the incident. Providers are further required to submit, “upon request by the by the LME, other information obtained regarding the incident, including:

- hospital records including confidential information;
- reports by other authorities; and
- the provider’s response to the incident.”

When updating an incident report, the supervisor of a provider agency needs to provide information

regarding the reason for the resubmission of incident report in the boxes on the Supervisor Action section of the incident Report.

Reporting of Abuse, Neglect and/or Exploitation:

- Must be reported to the appropriate agencies within the required timelines
- Report to the New Horizon CEO immediately
- Verbal report to the Host MCO immediately
- IRIS System upload within 72 hours
- Begin internal investigation immediately reflecting:
 - Person interviewed
 - Date and time the interview was completed
 - Complete conversation that transpired during the interview, with each individual
 - Person’s name completing the investigation
- If the incident is alleging a staff person is the accused, a Health Care Registry report must be completed within 24 hrs.

Note: Reports to DHSR Health Care Personnel Registry regarding an allegation against an unlicensed staff in a licensed or unlicensed facility should be submitted within 24 hours of the agency becoming aware of the incident.

FOR FURTHER INFORMATION REGARDING REQUIREMENTS SEE THE DMH INCIDENT MANUAL (online and in the agency office)

PCP review and revision following an incident:

Standard of Operation: Incident Reporting

In addition to the requirement related to the completion of incident reporting, the following steps shall be followed:

- 1. The service Director or Manager or responsible QP will collaborate with the Operations Director regarding the determination whether a revision of the consumer's PCP is warranted.**
 - a. If warranted, meet with the Child & Family Treatment Team relevant to the incident.**
 - b. If warranted, immediately revise the present PCP goals, or develop a new goal related to addressing the new need.**
 - c. The consumer and the consumer's guardian shall always be involved with the Child & Family Treatment Team meeting and the review/revision of the PCP.**
- 2. Operations Director will email Quality Management Director and Compliance staff person with the decision regarding warranted PCP revisions.**
- 3. Quality Management Director and Compliance staff person will review the decision related to the need to revise the PCP goals compared to the incident details.**
- 4. Additional follow-up will be completed by the Quality Management Director and Compliance staff person, if warranted.**

Dev. 3-20-18

**NEW HORIZON, LLC
EMERGENCY DRILLS**

Site: New Horizon Group Home Address: [REDACTED] Lumber Bridge, NC

Date: April 28, 2018 Time Started: 7:00 am Time Completed: 7:10 am

Type of Drill: ☐ Fire ☐ Natural Disaster ☐ Power Failure ☐ Medical ☐ Violence
☒ Bomb Threat

Describe Simulation (How, What, When, Where): The phone rung in the Level IV facility and when Staff answered it the caller stated, "There is a bomb at that place". Staff asked where the bomb was while motioning to other Staff to remove them from the Home. While questioning the caller Staff assisted other Staff with directing all exiting the front door. Staff asked caller if he had placed the bomb. Staff asked caller his name. Staff received no responses from caller and proceeded to call 911 to report was told Staff over the phone by the caller. Staff was asked by 911 to cross the street from the Home and remain in an area that's safe until assistance arrives. Staff called the Director to inform of the situation. After checking inside and outside the facility it was discovered that the call was a prank. Staff were allowed to return to the facility. Staff called the Director to inform of the outcome.

Participants in drill(s): Staff

Name of Person Conducting Drill: Melba Conley

Was the building evacuated? ☒ Yes ☐ No

If no explain: _____

Were the individuals moved to a safe location and accounted for? ☒ Yes ☐ No

If no explain: _____

Were the emergency procedures followed? ☒ Yes ☐ No

If no which procedures were not followed?

Responses to drill(s): Cooperative.

Recommendations for improvement following drill simulation (if applicable): None during this drill.

Report Completed By: Melba D. Conley Date: 4/28/18

**NEW HORIZON, LLC
EMERGENCY DRILLS**

Site: New Horizon Group Home

Address: _____

LumberBridge, NC

Date: APRIL 28, 2018 Time Started: 9:30 am

Time Completed: 10:00 am

Type of Drill: ☒ Fire ☐ Natural Disaster ☐ Power Failure ☐ Medical ☐ Violence
☐ Bomb Threat

Describe Simulation (How, What, When, Where): Staff was assembled in the hallway of the Level IV Group Home to learn each route to be taken in the event of a fire. Staff was explained the importance of Staff remaining calm to prevent everyone from becoming overwhelmed and/or panicky, and able to ensure that all are accounted for. How to exit the building in a safe and timely manner with everyone was demonstrated. At each exit Staff was instructed on how to lead us out into the farthest sections of the yard to include; the left side of the building and the backyard. Staff when assembled outside was asked to call 911 and to follow the 911 instructions. Staff was also asked to call the Director after the 911 call to inform of the situation.

Participants in drill(s): New Horizon Staff.

Name of Person Conducting Drill: Melba Conley

Was the building evacuated? ☒ Yes ☐ No

If no explain: _____

Were the individuals moved to a safe location and accounted for? ☒ Yes ☐ No

If no explain: _____

Were the emergency procedures followed? ☒ Yes ☐ No

If no which procedures were not followed? _____

Responses to drill(s): Cooperative.

Recommendations for improvement following drill simulation (if applicable): No recommendations during this drill.

Report Completed By: Melba D. Conley

Date: 4/28/18

New Horizon Group Home, LLC

This is to Certify that

Dorrell Bailey
has completed

CLIENT RIGHTS

(1hr)

4/21/2018
Date

Ashley W. Dyer, MS, CCL, LACS
Signature

New Horizon Group Home, LLC



This is to Certify that

Nyshella Smith
has completed

CLIENT RIGHTS

(1hr)

4/21/2014
Date

Ashley M. Smith, MSW, CPS
Signature



New Horizon Group Home, LLC

This is to Certify that

Shaunda Smith
has completed

CLIENT RIGHTS

(1hr)

4/21/2018
Date

Shirley W. Jones, MS, Ed, PCS
Signature



New Horizon Group Home, LLC

This is to Certify that

Lakeshaw Beaugregard
has completed

CLIENT RIGHTS

(1hr)

4/21/2018
Date

A. Beaugregard, M.Ed., CCS
Signature



New Horizon Group Home, LLC

This is to Certify that

Wendy Chavis
has completed

CLIENT RIGHTS

(1hr)

4/24/2018
Date

Shirley D. Jones, M.Ed., CASS
Signature



New Horizon Group Home, LLC

This is to Certify that

Cleveland Kealon
has completed

CLIENT RIGHTS

(1hr)

4/21/2018
Date

Shuley W. J. W. Ed, CRJ
Signature





New Horizon Group Home, LLC

This is to Certify that

Melba Conley

has completed

CLIENT RIGHTS

(1hr)



4/21/2018
Date



Shelley J. Jones, MS, Ed, QPS
Signature



New Horizon Group Home, LLC

This is to Certify that

Sean Evans
has completed

CLIENT RIGHTS



(1hr)

4/21/2018
Date



Shelley W. Kelly, MS, Ed, CAS
Signature

New Horizon Group Home, LLC

This is to Certify that

Anthony Bears
has completed

CLIENT RIGHTS

(1hr)

4/21/2018
Date

Shirley W. Jones, LLC
Signature





New Horizon Group Home, LLC

This is to Certify that

Darrell Baley
has completed

INCIDENT REPORTING

(2hrs)

4/21/2018
Date



Melley J. Baley, MS Ed, CAS
Signature



New Horizon Group Home, LLC

This is to Certify that

Nyshella Smith
has completed

INCIDENT REPORTING

(2hrs)

4/21/2018
Date

Shelley D. Jones, MSW, CPS
Signature



New Horizon Group Home, LLC



This is to Certify that

Shaunda Chappel

has completed

INCIDENT REPORTING

(2hrs)

4/21/2018
Date



Shaunda Chappel, Ed, CES
Signature

New Horizon Group Home, LLC

This is to Certify that

Wendy Chavis
has completed

INCIDENT REPORTING

(2hrs)

11/21/2018
Date

Shulea W. Byrd, MS, Ed, CPS
Signature





New Horizon Group Home, LLC

This is to Certify that

Lakeshaw Beaugregard

has completed

INCIDENT REPORTING

(2hrs)

4/21/2018
Date



Shuley D. Dyer, M.S., Ed., CASS
Signature



New Horizon Group Home, LLC

This is to Certify that

Melba Conley
has completed

INCIDENT REPORTING

(2hrs)

4/21/2018
Date

Melba Conley, MSW, CCS
Signature





New Horizon Group Home, LLC

This is to Certify that

Cleveland Kealon
has completed



INCIDENT REPORTING

(2hrs)

4/11/2018
Date



Shuley H. Hays, MSSW, CAS
Signature

New Horizon Group Home, LLC

This is to Certify that

Sean Evans
has completed

INCIDENT REPORTING

(2hrs)

Date

4/21/2018

Signature

Muley, MS, Ed, CPS

New Horizon Group Home, LLC

This is to Certify that

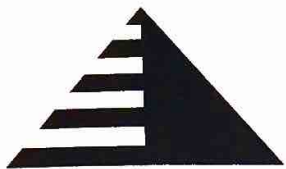
Anthony Bears
has completed

INCIDENT REPORTING

(2hrs)

4/24/2018
Date

Shelley D. Thomas, Ed, CRS
Signature



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

RESIDENTIAL LEVEL IV LICENSED PROFESSIONAL JOB DESCRIPTION

Provider Requirements:

New Horizon Group Home, LLC is certified as a Critical Access Behavioral Healthcare Agency (CABHA) provider through NC Division of MH/DD/SAS and is credentialed by Sandhills Center and Eastpointe Managed Care Organizations. New Horizon Group Home also is nationally accredited by Commission on Accreditation of Rehabilitation Facilities (CARF). The agency meets all the provider qualifications established by Division of Medical Assistance, Division of MH/DD/SAS, and the Managed Care Organizations (MCO).

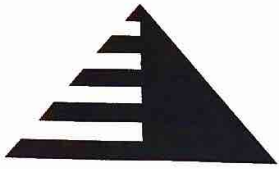
Residential Treatment Level IV is an intensive residential treatment facility that is a 24-hour residential facility which provides a structured living environment within a system of care approach for children or adolescents whose primary diagnosis is mental illness, some of whom may also have co-occurring diagnoses, and for whom removal from home is essential to facilitate treatment. The needs of the children/adolescents require more intensive treatment and supervision than would be available in a residential treatment facility offering only a staff secure setting.

Primary Purpose of the Position:

New Horizon Group Home, LLC offers psycho-educational and relational support, behavioral modeling of interventions, and supervision to the consumer residing in the facility. These preplanned therapeutically structured interventions occur as required and outlined in the consumer's service plan. Staff also monitor, treat, and assess the emotional, psychiatric, and behavioral needs of this population, and assist with coordinating service needs. The Licensed Professional (LP) will assist in the development of symptom and behavior management skills; include intensive, frequent, and pre-planned crisis management; provide containment and safety from potentially harmful or destructive behaviors; promote involvement in regular productive activity, such as school or work; support the consumer in gaining the skills needed for reintegration into community living; and coordinate with other individuals and agencies within the consumer's system of care. The LP will work with the Qualified Professional team and all other facility staff to assist consumers in unlearning maladaptive behaviors and develop more appropriate relationship skills. Duties are performed primarily in the residential facility but may also include other areas in the community.

The Licensed Professional is a full-time licensed position in the facility being involved with the clinical and administrative aspects of the consumers services, to include but not limited to:

- Supervision of direct care staff;
- Oversight of emergencies;
- Provision of direct clinical psychoeducational services to consumers and their families;
- Participation in treatment planning meetings; and
- Coordination of each consumer's treatment plan.



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

Accountability:

The Licensed Professional position works as an integral part of the clinical and administrative team at the facility.

Qualifications:

Licensed Professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of NC. For substance related disorders this shall include a Licensed Clinical Addiction Specialist or a Certified Clinical Supervisor.

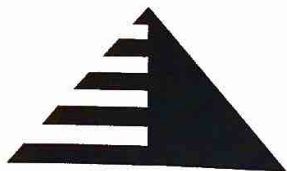
Staffing Requirements:

Residential Treatment Level IV requires a minimum of three direct care staff per six consumers; four direct care per seven, eight, or nine consumers; and five direct care staff per ten, eleven, or twelve consumers, always.

During consumer sleep hours, three direct care staff shall be present of which two shall be awake and the third may be asleep. In addition to the minimum number of direct care staff, more direct care staff may be required in the facility based on the consumer's individual needs as specified in the treatment plan.

Special Knowledge, Skill, Physical Requirements, and Training:

- Knowledge of State and Medicaid requirements as they relate to the provision of Residential Treatment services.
- Expertise with Sex Offender techniques to provide service as well as supervise the staff in this subject matter.
- General understanding of behavioral patterns and attitudes common in varying degrees with children/adolescents in the MH/SA populations;
- Ability to deal patiently and fairly with staff, consumers, families, and others;
- Ability to maintain effective and efficient working relationships and present an atmosphere of teamwork;
- Consistently aware of health and safety needs for all consumers and staff;
- Demonstrate good oral, written, and documentation skills;
- Regular and predictable job attendance;
- Ability to accept and respond positively to change;
- Training/certification in the following:
 - General Organization Orientation



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

- Client's Rights
- HIPPA Laws and Confidentiality
- Person Centered Planning
- Person Centered Thinking
- Cultural Awareness
- Specific Population characteristics of consumers being served
- Documentation requirements and skills
- Crisis Intervention
- Incident Reporting
- Supervision Techniques
- CPR/1st Aid/Blood Borne Pathogens
- NCI or equivalent
- Sex Offender training, if required to meet consumer's needs

Equipment Regularly Used:

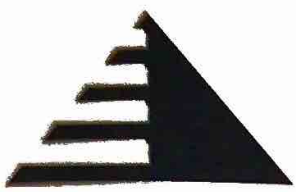
- Computer
- Phone
- Cell Phone
- Copier machine
- Fax machine
- Agency vehicle and personal vehicle

Licenses or Certifications Required:

- License or Provisional license issued by the governing board regulating a human service profession in the State of NC.
- Sex Offender training, if indicated in the consumer's treatment plan
- Valid North Carolina Driver's license, which is clear of violation reflecting a poor driving record
- Personal vehicle insurance as required

Minimum Qualifications:

The employee must have the ability to read and analyze/interpret journals, technical procedures, and government regulations. The employee must have the ability to assess and develop the Person-Centered Plans and communicate effectively both in writing and orally. Employee must also have the ability to write reports, business correspondence, and procedure manuals. The LP must be able to present information to participants and their families, community support groups, other qualified professionals, paraprofessionals, and the public.



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

Language Skills:

Employee must have the ability to read, analyze, and interpret general business periodicals, professional journals, technical, procedures, or governmental regulations. Employee must also have the ability to write reports, business correspondence, and procedure manuals.

Physical Demand/Work Environment:

Equitable and reasonable accommodations may be made to enable individual with disabilities to perform essential functions.

Other Requirements/Confidentiality:

Employee must adhere to the Health Insurance Portability and Accountability Act (HIPPA). Adhere to New Horizon Group Home, LLC, Policies and Procedures. Perform other duties that may be assigned by the supervisor, Director of Operations, and/or Executive/CEO.

Ethics and Compliance:

New Horizon Group Home, LLC Code of Ethics is intended to prevent, detect, and correct violations of the law, rules, and policies by employees. The core values of the Code of Ethics include a commitment to the dignity, well-being and self-determination of the members served. Staff of NHGH will maintain the privacy, confidentiality and rights of members served.

New Horizon Group Home, LLC seeks to provide competent evidence-based services, treatment and supports in a manner that is respectful of the dignity and worth of every individual (and their families) with a mental health diagnosis. New Horizon Group Home, LLC holds employees to certain standards of conduct that require them to use a clear set of values which guide their decision-making process and way they approach consumers. No employee, supervisor or management person of New Horizon Group Home, LLC has the authority to direct any other employee to act or do anything that violates company policies and procedures, local, state, or federal laws or regulations or the New Horizon Group Home Standards of Conduct. New Horizon Group Home will take prompt and complete action, up to and including termination of employment, and filing of civil or criminal charges leading to the adjudication by a court of competent authority.

Agreement:

I have read and understand the Licensed Professional Job Description. I understand that from this point forward I will be responsible for complying with these guidelines. Failure to comply may result in a disciplinary action up to and including termination.

Signature of Licensed Professional

Thomas McMillan, MSW, APC

Date

4-25-18



**Licensed as a Registered Nurse
in North Carolina**

Certificate No. 098395

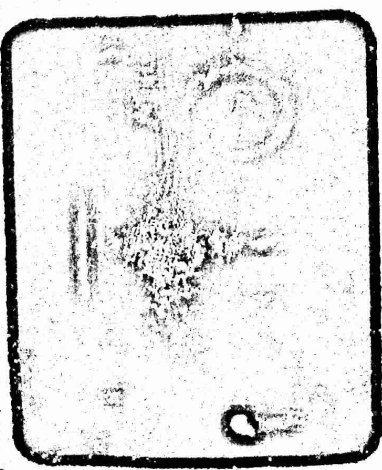
Renewal No. 075248

Expiration: MAR. 31, 2007

SHARON LITTLE KNOTTS

4583 COUNTRY CLUB ROAD

WADESBORO NC 28170



Sharon Little Knotts

Executive Director

Expire 3/31/2019 # 098395

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Cleveland Kealon

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES

INSTRUCTOR SHARON KNOTTS, RN MSN



4/15/18

April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

certify satisfactory completion of

Medication Administration for Unlicensed Personnel in Community Facilities

Sharon Knottis RN MSN, Instructor

Sharon Knottis RN MSN

Date: *April 14, 2018*

Renewal Date: *April 30, 2019*

* This is the certificate that I
used for previous trainings done
with all New Horizon Staff
for medication management
Sharon

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

LOVE HICKS

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

SR

Sharon Smith for MSN

February 27, 2018

Renewal February 27, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Love Hicks

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

SR
Sharon Smith for MSN

February 27, 2018
Renewal February 27, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Robert Pipkin

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

52

Sharon Mullett for MSN

February 23, 2018

Revised February 28, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Justin Bing

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

Sh

Sharon Brooks RN MSN

February 22, 2018

Renewal February 28, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Charlene Ross

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

Sharon

huddell calmsn

February 22, 2018

Renewed February 28, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Richard Clanton

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

SK
Sharon Brooks RN MSN

February 22, 2018
Renewed February 28, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Wendy McMillian

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

SR

Sharon Knott's 1st Person

March 7, 2017

Renewed March 30, 2018

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Anthony Beas

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

By

Sharon Wrights Fenman

March 7, 2018

Renewed March 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Marcell Sinclair

TO CERTIFY THEIR SATISFACTORY COMPLETION OF THE MEDICATION ADMINISTRATION
FOR UNLICENSED PERSONAL IN COMMUNITY FACILITIES

[Signature]
Sharon Wootts RN MSN

February 22, 2018
Renewal February 28, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Anthony Bears

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES


INSTRUCTOR SHARON KNOTTS, RN MSN


April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Melba Conley

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES



INSTRUCTOR SHARON KNOTTS, RN MSN

4/15/18

April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Sean Evans

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES



INSTRUCTOR SHARON KNOTTS, RN MSN

4/15/18

April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Marcus Sinclair

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES



INSTRUCTOR SHARON KNOTTS, RN MSN

4/15/18

April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Charlene Ross

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES



INSTRUCTOR SHARON KNOTTS, RN MSN

4/15/18

April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Richard Clanton

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES



INSTRUCTOR SHARON KNOTTS, RN MSN

4/15/18

April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Monty Little

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES


INSTRUCTOR SHARON KNOTTS, RN MSN


April 15, 2018
Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Keith Locklear

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES


INSTRUCTOR SHARON KNOTTS, RN MSN


April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Mia Fuller

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES

INSTRUCTOR SHARON KNOTTS, RN MSN

4/15/18
April 15, 2018

Renewal April 30, 2019


Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

Mia Fuller

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES


INSTRUCTOR SHARON KNOTTS, RN MSN


April 15, 2018

Renewal April 30, 2019

Certificate of Achievement

THIS CERTIFICATE IS PRESENTED TO

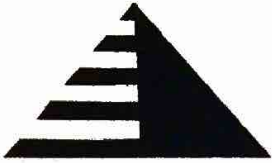
Jacqueline Cagle

FOR SATISFACTORY COURSE COMPLETION OF
MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL
IN COMMUNITY FACILITIES


INSTRUCTOR SHARON KNOTTS, RN MSN


April 15, 2018

Renewal April 30, 2019



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

RESIDENTIAL LEVEL IV QUALIFIED PROFESSIONAL JOB DESCRIPTION

Provider Requirements:

New Horizon Group Home, LLC is certified as a Critical Access Behavioral Healthcare Agency (CABHA) provider through NC Division of MH/DD/SAS and is credentialed by Sandhills Center and Eastpointe Managed Care Organizations. New Horizon Group Home also is nationally accredited by Commission on Accreditation of Rehabilitation Facilities (CARF). The agency meets all the provider qualifications established by Division of Medical Assistance, Division of MH/DD/SAS, and the Managed Care Organizations (MCO).

Residential Treatment Level IV is an intensive residential treatment facility that is a 24-hour residential facility which provides a structured living environment within a system of care approach for children or adolescents whose primary diagnosis is mental illness, some of whom may also have co-occurring diagnoses, and for whom removal from home is essential to facilitate treatment. The needs of the children/adolescents require more intensive treatment and supervision than would be available in a residential treatment facility offering only a staff secure setting.

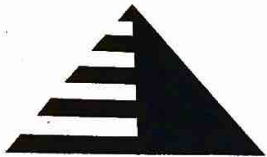
Minimum Staffing Requirements for the Facility:

The minimum number of direct care staff required when children or adolescents are present and awake is as follows:

- Three direct care staff shall be present for up to six children or adolescents;
- Four direct care staff shall be present for seven, eight or nine children or adolescents; and
- Five direct care staff shall be present for 10, 11 or 12 children or adolescents.
- During child or adolescent sleep hours three direct care staff shall be present of which two shall be awake and the third may be asleep.
- More direct care staff may be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.

Primary Purpose of the Position:

New Horizon Group Home, LLC offers psycho-educational and relational support, behavioral modeling of interventions, and supervision to the consumer residing in the facility. These preplanned therapeutically structured interventions occur as required and outlined in the consumer's service plan. Staff also monitor, treat, and assess the emotional, psychiatric, and behavioral needs of this population, and assist with coordinating service needs. The Qualified Professional (QP) will provide individualized, intensive, and constant supervision and structure of daily living designed to minimize the occurrence of oppositional behavior, to ensure safety and maintain optimum level of functioning. The QP will work with the Licensed Professional team and all other facility staff to assist consumers in unlearning



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

maladaptive behaviors and develop more appropriate relationship skills. Duties are performed primarily in the residential facility but may also include other areas in the community.

Accountability:

The Qualified Professional position is under the supervision and guidance of the Director of Operations and/or Clinical Director and is subject to a performance review and appraisal at least once per year.

Requirements of the Qualified Professional Position:

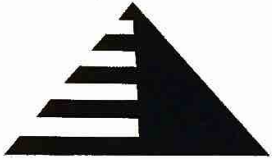
The Qualified Professional is a full-time employee with two years of direct consumer care experience. The Qualified Professional parameters:

- shall perform clinical and administrative responsibilities a minimum of 40 hours each week; and
- 75% shall occur when children or adolescents are awake and present in the facility.
- shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes always.

Qualifications:

"Qualified professional" means, within the MH/DD/SAS system of care:

- (a) an individual who holds a license, provisional license, certificate, registration, or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SAS with the population served; or
- (b) a graduate of a college or university with a master's degree in a human service field one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- (c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- (d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

Provider Requirements and Supervision related to the service:

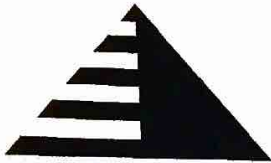
The minimal requirements are (depending on the position):

- a high school diploma or GED, associate degree with one year of experience, or
 - a four-year degree in the human service field, or
 - a combination of experience, skills, and competencies that is equivalent, plus:
 - Skills and competencies of this service provider must be at a level that includes structured interventions in a contained setting to assist the consumer in acquiring control over acute behaviors.
 - Sex Offender Specific Service Provision: In addition to the above, when the consumer requires sex offender specific treatment, as outlined in their treatment plan, special training of the caregiver is required in all aspects of sex offender specific treatment. Implementation of therapeutic gains is to be the goal of the placement setting.
- AND
- Supervision is provided by a Qualified Professional with sex offender specific treatment expertise is on-site per shift.
Must meet requirements established by state personnel system or equivalent for job classifications. Supervision provided by qualified personnel as stated in 10 NCAC 27G rules regarding Professionals and Paraprofessionals.

Minimum direct care staff to children/adolescents of two direct care staff per six consumers always, including sleep hours.

Special Knowledge, Skill, Physical Requirements, and Training:

- Knowledge of State and Medicaid requirements as they relate to the provision of Residential Treatment services.
- Expertise with Sex Offender techniques to provide service as well as supervise the staff in this subject matter.
- General understanding of behavioral patterns and attitudes common in varying degrees with children/adolescents in the MH/SA populations;
- Ability to deal patiently and fairly with staff, consumers, families, and others;
- Ability to maintain effective and efficient working relationships and present an atmosphere of teamwork;
- Consistently aware of health and safety needs for all consumers and staff;
- Demonstrate good oral, written, and documentation skills;
- Regular and predictable job attendance;
- Ability to accept and respond positively to change;
- Training/certification in the following:
 - General Organization Orientation
 - Client's Rights



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

- HIPPA Laws and Confidentiality
- Person Centered Planning
- Person Centered Thinking
- Cultural Awareness
- Specific Population characteristics of consumers being served
- Documentation requirements and skills
- Crisis Intervention
- Incident Reporting
- Supervision Techniques
- CPR/1st Aid/Blood Borne Pathogens
- NCI or equivalent
- Sex Offender training, if required to meet consumer's needs

Equipment Regularly Used:

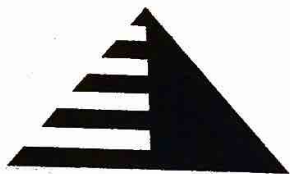
- Computer
- Phone
- Cell Phone
- Copier machine
- Fax machine
- Agency vehicle and personal vehicle

Licenses or Certifications Required:

- Sex Offender training, if indicated in the consumer's treatment plan
- Valid North Carolina Driver's license, which is clear of violation reflecting a poor driving record
- Personal vehicle insurance as required

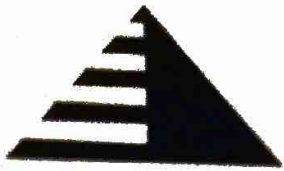
Job Duties and Responsibilities:

1. Management of the day to day operations of the facility;
2. Supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan;
3. Participation in treatment planning meetings; and
4. Provision of basic case management functions.
5. Actively involved in program development, implementation, and service delivery.
6. Coordinates the assessment and reassessment of the consumer's clinical needs.
7. Convening the Child and Family Team for person-centered planning.
8. Assessing the child's/adolescent's needs for additional service needs.
9. Completing the initial development and ongoing revision of the Person-Centered Plan and ensuring its implementation.
10. Consulting with identified collateral contacts and natural supports and including their input in the person-centered planning process.
11. Ensuring linkage for any additional evaluations/assessments for the consumer.



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

12. Monitoring the provision of services and supports, psychiatric symptoms, and documenting the status of the consumer's progress and the effectiveness of the strategies and interventions outlined in the Person-Centered Plan.
13. Assisting with crisis interventions;
14. Collaborate with the Local Education Authority and other service providers as needed for the consumer's service provision.
15. Provide interventions designed to reduce symptoms, improve behavioral functioning, increase the consumer's ability to cope with and relate to others, and promote recovery.
16. Ability to provide healthy and appropriate adult role models.
17. Administer medication as prescribed using safe medication administration practices.
18. Ability to document relevant and significant observations regarding consumer behaviors as they relate to actualizing therapeutic and treatment plan goals.
19. Remain cognizant of consumer rights and confidentiality always and during all interactions with the consumers.
20. Attend all mandatory trainings, in-service trainings, and other conferences that relate to assigned and direct care duties.
21. Responsible for the care and development of the consumers. Assist consumers in the development of self-help skills (i.e., classroom activities, social skills, etiquette and social relationships, and other activities).
22. Transport consumers to appointments and other events as indicated on the activity list and/or the consumer's treatment plan.
23. Maintain positive relationship in interpersonal dynamics which typically provoke rejection, hostility, anger, and avoidance.
24. Maintains composure in intense situations that may arise when grossly inappropriate behaviors occur and effectively calm consumer through verbal non-aggressive techniques or protective interventions.
25. Guides and instructs consumers toward accomplishment of goals within the consumer's Person-Centered Plan.
26. Assess and monitor a consumer's progress and psychiatric/emotional stability.
27. Assist consumers with necessary treatment and service needs.
28. Providing education and support to consumers and families related to the symptoms of the mental health and other possible co-occurring diagnoses the consumer is experiencing.
29. Provide intensified structure and supervision to consumers.
30. Maintain accurate and timely documentation of the services interventions and the outcomes relevant to the consumers treatment needs.
31. Attend and participate in scheduled administrative staff meetings.
32. Serve on internal agency committees, such as QA/QI, Client Rights, and employee committees, etc.
33. Provide special consultation in consumer and stakeholder satisfaction studies and other quality improvement activities.
34. Participate in scheduled and unscheduled clinical and administrative supervisions.



New Horizon, LLC
4989 Rockfish Rd
Raeeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

35. Maintain and enhance clinical skills through professional readings and attendance at recommended training events.
36. Other activities, that relate to job title duties.

Minimum Qualifications:

The employee must have the ability to read and analyze/interpret journals, technical procedures, and government regulations. The employee must have the ability to assess and develop the Person-Centered Plans and communicate effectively both in writing and orally. Employee must also have the ability to write reports, business correspondence, and procedure manuals. The QP must be able to present information to participants and their families, community support groups, other qualified professionals, paraprofessionals, and the public.

Language Skills:

Employee must have the ability to read, analyze, and interpret general business periodicals, professional journals, technical, procedures, or governmental regulations. Employee must also have the ability to write reports, business correspondence, and procedure manuals.

Physical Demand/Work Environment:

Equitable and reasonable accommodations may be made to enable individual with disabilities to perform essential functions.

Other Requirements/Confidentiality:

Employee must adhere to the Health Insurance Portability and Accountability Act (HIPPA). Adhere to New Horizon Group Home, LLC, Policies and Procedures. Perform other duties that may be assigned by the supervisor, Director of Operations, and/or Executive/CEO.

Ethics and Compliance:

New Horizon Group Home, LLC Code of Ethics is intended to prevent, detect, and correct violations of the law, rules, and policies by employees. The core values of the Code of Ethics include a commitment to the dignity, well-being and self-determination of the members served. Staff of NHGH will maintain the privacy, confidentiality and rights of members served.

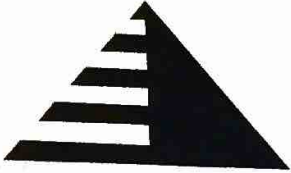
New Horizon Group Home, LLC seeks to provide competent evidence-based services, treatment and supports in a manner that is respectful of the dignity and worth of every individual (and their families) with a mental health diagnosis. New Horizon Group Home, LLC holds employees to certain standards of conduct that require them to use a clear set of values which guide their decision-making process and way they approach consumers. No employee, supervisor or management person of New Horizon Group Home, LLC has the authority to direct any other employee to act or do anything that violates company policies and procedures, local, state, or federal laws or regulations or the New Horizon Group Home Standards of Conduct. New Horizon Group Home will take prompt and complete action, up to and

Qualified Professional Job Description

New Horizon, LLC

Revised Edition 4-20-18

page 6 of 7



New Horizon, LLC
4989 Rockfish Rd
Raeford, NC 28376
Phone: (910) 848-1080
Fax: (910) 848-1819

including termination of employment, and filing of civil or criminal charges leading to the adjudication by a court of competent authority.

Agreement:

I have read and understand the Qualified Professional Job Description. I understand that from this point forward I will be responsible for complying with these guidelines. Failure to comply may result in a disciplinary action up to and including termination.

Melinda D. Conley BS/DP

Signature of Qualified Professional

4/25/18

Date

[Signature]

Supervisor's Signature

4/25/18

Date

North Carolina Interventions

Agency is responsible for verifying Instructor certification.

Go to DMH/DD/SAS website:
<http://www.ncdmh.net/NCI-Public/index.htm>

NC Instructor

This certifies that

Beyan Holley

has fulfilled all requirements for certification and is qualified to teach

NCI Interventions - Core + Training

(Parts A and B+ designated optional physical techniques)

This individual is certified in 15 optional physical techniques (see back)

A curriculum of the NC Division of Mental Health, Development Disabilities and
Substance Abuse Services

Greg Hall
Instructor Trainer Name

Greg Hall
Instructor Trainer Signatures

Date 6-30-2017
Certificate is valid through Insert Expiration Date

New Horizons, LLC	Policy No.: P-1 Page 1 of 5
Subject: Personnel	Effective Date: 01/01/09
	Revised Date: 07/08/15; 09/01/15; 4/30/18

Policy

New Horizons, LLC employs and retains qualified personnel.

Procedures

1. The agency complies with all EEO and ADA requirements. The agency hires and maintains the most qualified person for a position and does not discriminate against race, gender, disability, ethnicity, nation of origin, sexual orientation, or religion.
2. Employees/Contractors meet all requirements specified in rules and regulations governing MH/DD/SA Services. Employees/Contractors are currently licensed, registered or certified in accordance with applicable state laws for the services provided and meet basic requirements for respective positions as outlined in the job descriptions, rules and regulations and personnel policies.
3. Employees/Contractors or any other person who provides services to consumers on behalf of New Horizons, LLC:
 - a. are at least eighteen years of age;
 - b. are able to read, write, and understand and follow directions;
 - c. meet the minimum level of education, competency, work experience, skills, and other qualifications for the position; and
 - d. has no substantiated findings of abuse or neglect listed on the N.C. Health Care Personnel Registry.
4. All applicants for employment or volunteer must disclose any criminal convictions and prior to hiring sign a release for information to be obtained. Criminal background and Health Care Registry checks are conducted on all new employees, contractors, and volunteers. Updates are conducted "for cause" and/or per request of the CEO whenever there is an indication of possible changes.
 - a. Applicants who have been a resident of North Carolina for less than five years must have a State and National criminal history check. National criminal history record checks include a check of the applicant's fingerprints.
 - b. Applicants who have been a resident of North Carolina for five years or more have a State criminal history check.
 - c. All criminal history information received by New Horizons, LLC is confidential and may not be disclosed, except to the applicant under the

New Horizons, LLC	Policy No.: P-1 Page 2 of 5
Subject: Personnel	Effective Date: 01/01/09
	Revised Date: 07/08/15; 09/01/15; 4/30/18

- following condition: If New Horizons, LLC disqualifies an applicant after consideration of the relevant factors, the agency may disclose information contained in the criminal history record check that is relevant to the disqualification but may not provide a copy of the criminal history record check to the applicant.
- d. The fact of a conviction of a relevant offense alone does not bar employment; however, factors are considered by New Horizons, LLC. If an applicant's criminal history record check reveals one or more convictions of a relevant offense, New Horizons, LLC considers all of the following factors in determining whether to hire the applicant:
 - level and seriousness of the crime;
 - date of the crime;
 - age of the person at the time of the conviction;
 - circumstances surrounding the commission of the crime, if known;
 - criminal conduct of the person and the job duties of the position to be filled;
 - prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed; and
 - subsequent commission by the person of a relevant offense.
 - e. New Horizon, LLC may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if the following conditions are met:
 - New Horizons, LLC does not employ an applicant prior to obtaining the applicant's consent for criminal history record check or the completed fingerprint cards as required in G.S. 114-19.10 and the request for the criminal history record check must be within five business days of the offer of conditional employment.
 - The employee/contractor is not allowed to be alone with consumers.
 - f. New Horizon, LLC does not fingerprint nor require staff/personnel to be fingerprinted.
5. A written job description is developed for all employees, which:
 - a. specifies the minimum level of education, competency, work experience, and other qualifications for the position;
 - b. specifies the duties and responsibilities of the position; and
 - c. is signed by the employee/contractor and the supervisor.
 6. Personnel files are the property of New Horizons, LLC. All personnel records are maintained in a designated, locked file cabinet and access is only by the CEO or designee. Employees/Contractors who want to review their files must arrange review with the CEO and only have access to allowed information.

New Horizons, LLC	Policy No.: P-1 Page 3 of 5
Subject: Personnel	Effective Date: 01/01/09
	Revised Date: 07/08/15; 09/01/15; 4/30/18

7. A file is maintained on each employee/contractor that includes:
 - a. application for employment;
 - b. signed job description that identifies the required educational, licensure credentials, and other qualifications for the job;
 - c. in-service training;
 - d. verification of experience, credentials, and other qualifications for the position, including transcripts, and current licensure/registration/certification;
 - e. the results from the criminal background checks, driving and Health Care Registry checks, and verification that sanctions from professional boards and/or health care registry have been reviewed;
 - f. clinical supervision and documentation of clinical supervision plans and activities, when supervision is required;
 - g. performance evaluations (at least annually);
 - h. evidence of orientation; and
 - i. verification of current automobile insurance coverage.
8. All continuing education relevant to employment is documented.
9. At least one staff person is available at all times that is trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.
10. When an employee/contractor is unable to work as scheduled, he/she informs the supervisor in order for coverage to be arranged if needed.
 - a. The supervisor takes into account all available staff, their primary responsibilities, and any special circumstances in filling absences.
 - b. Every effort is made to assure that staff who act as back-up are trained to the specifications required for the consumer for whom they are providing services, including any specific training.
11. New Horizons, LLC ensures that back up staff is available when the lack of immediate care would pose a serious threat to the consumer's health and welfare and formal providers are unavailable. New Horizons, LLC documents who provides services in the absence of the direct service employee/contractor.

Credentials

New Horizons, LLC	Policy No.: P-1 Page 4 of 5
Subject: Personnel	Effective Date: 01/01/09
	Revised Date: 07/08/15; 09/01/15; 4/30/18

The employee/contractor is responsible for providing information in order for verification of credentials and maintaining current copies of any license, registration or certification. The employee/contractor must provide initial verification from the primary source, e.g. an original educational transcripts or verification of school/degree completion, prior to hire or when obtained. In the event a potential staff member holds a license from a state other than North Carolina New Horizon will follow the standards set for the specific licensure board as well as all state and federal guidelines. The CEO will contact the primary source if there is any question or concern about authenticity. The CEO or designee verifies license/certifications directly by contacting the granting organization. In the event credentials cannot be verified, the person is not employed.

Grievance

Employees may file a grievance or appeal personnel actions taken to the CEO. The grievance or appeal must be in written format with specific information noted to assist the CEO in the investigation. The CEO provides written response to the employee within 15 working days of receipt of the report noting actions taken on the grievance/appeal. The CEO has final decision.

Dismissal

Persons are employed "at will" by the CEO. An employee and/or contractor may be dismissed from the agency by the CEO for just cause, e.g. subjecting the persons served to harm or fraudulent documentation. The CEO may contact the agency's attorney to obtain legal clarification prior to dismissal. Dismissal by the CEO is not appealable.

Performance Evaluations

Performance evaluations for all personnel are conducted at least annually that are:

1. Based on job functions and competencies identified;
2. Evident in personnel files;
3. Conducted in collaboration with the immediate supervisor with evidence of input from the personnel being evaluated; and
4. Used to assess performance related to objectives established in the last evaluation period and establish objectives for the next year.

Hiring, Promotions and Work Assignment

The CEO is responsible for recruitment and hiring of staff members. Vacant positions are shared during staff meetings and filled internally if staff is qualified. Applications are received and screened for appropriate credentials/requirements

New Horizons, LLC	Policy No.: P-1 Page 5 of 5
Subject: Personnel	Effective Date: 01/01/09
	Revised Date: 07/08/15; 09/01/15; 4/30/18

and experience by the CEO. The CEO selects the qualified candidates who are interviewed by the CEO and others as requested by the CEO and the position is offered to the most qualified candidate. Monetary compensation is based on the local market and qualifications/experience of the employee and/or representative.

Work assignments are based on the service definitions requirements, expertise of the employee/contractor and needs of the persons served. New employees/contractors are not provided a full workload until the supervisor reports that the employee/contractor is capable of providing qualified work to more persons. At no time does the workload exceed state requirements.

The CEO makes promotions based on the employee and/or representative attaining the experience/training required in the job description, e.g. Associate Professional being moved to a Qualified Professional.

New Horizon Group Home, LLC**Service: Intensive In-Home/Personnel**

Requirement:	Review	Review	Review
1. Job application indicating Disclosure of Criminal convictions			
2. References verifying past employment with population			
3. Copy of highest degree earned			
4. College transcript for QP			
5. Job description with all of the service required elements			
6. Orientation			
7. Training on meeting the consumer's MH/DD/SAS needs (training on diagnosis/review of PCP goals and strategies, etc)			
8. Client Rights			
9. Confidentiality			
10. Blood Borne Pathogens			
11. CPR			
12. 1 st Aid			
13. Med Adm			
14. NCI or CPI			
15. Criminal background checks (including DMV) (if lived outside of NC within the past 5 years – need national)-prior to hire			
16. N C Health Care Registry – prior to hire			
17. Meets the competency level for the position: Licensed or Provisionally Licensed with one year child mh/dd/sas Qualified Professional with two years exp child mh/dd/sas At least AP level with one year exp child mh/dd/sas			

18. Supervision Plan			
19. Supervision documentation per plan			
20. Copy of license: professional, if applicable			
21. Drivers license			
22. PPD			
Service required training within timelines:			
<p>All staff: 30 days</p> <p>23. 3 hrs Intensive In-Home service definition</p> <p>24. 3 hrs Crisis Response</p> <p>Team Lead & QP: 30 days</p> <p>25. PCP Instructional Elements</p> <p>Team Leads: 90 days or 3-31-11</p> <p>26. 13 hrs Motivational Interviewing</p> <p>27. 12 hrs Person Centered Thinking</p> <p>28. 11 hrs SOC</p> <p>Team staff: 90 days</p> <p>29. 13 hrs Motivational Interviewing</p> <p>30. 12 hrs Person Centered Thinking</p> <p>31. 11 hrs SOC</p> <p>All staff</p> <p>32. CBT Training: To ensure the core fundamental elements of training specific to the modality** selected by the agency for the provision of services are implemented a minimum of 24 hours of the selected modality must be completed.</p> <p>Team Leads and/or supervisory level</p> <p>33. All supervisory level training required by the developer of the designated therapy, practice or model with a minimum of 12 hours must be completed.</p> <p>All staff annually</p> <p>34. Follow up training and ongoing continuing education required for fidelity to chosen modality** (If no requirements are designated by developers of that</p>			

modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed.). 10 hrs CBT Model			
Approval Rate:			

Comments on back side

Rev 3-11-17

NEW HORIZON GROUP HOME

Orientation Checklist

Employee Name _____ Hire Date _____

COMPLETED

Initials- Employee/Designated
Agency Staff

DATE _____

*****Warning: no staff person can be put onto a shift schedule until having completed NCI/CPI and Medication Administration, Client Rights, Confidentiality, Documentation training.**

Prior to First Day

*****Warning: the below paperwork items MUST be completed prior to hire offer! No potential employees can be offered a job without CEO having received evidence the prior to hire paperwork has been completed.**

*****A copy of this form, reflecting the prior to hire paperwork completion, must be forwarded to the CEO/Owner prior to job offer**

*****The Criminal Background Check must be requested at least five business days prior to the offer of conditional employment.**

Administrative Assistant

I. Paperwork Complete

Criminal record check

NC Health Care Registry

NCI or CPI

DMV report

First Day of Work

Quality Management Director

Mission, Values, Vision statement

NH Policy Manual

Review Personnel Policy Manual

Sexual harassment

Ethics

Cultural Diversity

Review Confidentiality Manual

Review Client Rights Manual

Review Records Management and

Documentation Manual

NCTOPPS

Administrative Assistant

Workers Comp. Procedures	_____	_____
Hours of operation	_____	_____
Lunch breaks	_____	_____
Signing in/out	_____	_____
No overtime (unless given permission)	_____	_____
Holiday Schedule	_____	_____
Travel/reimbursement for appointed staff	_____	_____
Reporting sick or leave to personnel	_____	_____
Transportation (car/vehicle logs/care)	_____	_____
Mileage reports	_____	_____
Use of center vehicles	_____	_____
Use of seat belts	_____	_____
Transportation adaptive equipment	_____	_____
Emergency situation preparation	_____	_____
Emergency information on vehicles	_____	_____
Tour facility/introductions	_____	_____
Discuss work areas	_____	_____

Emergency Operations Plan

Adverse Weather	_____	_____
Fire Extinguishers	_____	_____
Fire drills	_____	_____
Evacuation Route	_____	_____
Written Fire Plan	_____	_____
Area Wide Disaster Plan	_____	_____
Health & Safety Plan	_____	_____
Location of fuse/breaker panels	_____	_____
Maintenance Concerns	_____	_____
Cleaning Concerns	_____	_____
Location of first aid kits	_____	_____
Provide copy of transportation log	_____	_____
Receive Key to Facility	_____	_____

Location of cabinets for vehicles	_____	_____
keys		
NH employee contact info &		
Agency phone numbers/fax	_____	_____
Personal phone use		
Team mobile phone #'s and use	_____	_____
Open door management (chain of command)	_____	_____
Dress Code	_____	_____
Drug Free environment	_____	_____
Resignation	_____	_____

Second Day of Work

Supervisor/Clinical Director

Review job description	_____	_____
Develop Supervision contract	_____	_____
-Monthly supervisions	_____	_____
-Discuss employee evaluation	_____	_____
process		

Review service notes/documentation	_____	_____
------------------------------------	-------	-------

Documentation in medical records	_____	_____
----------------------------------	-------	-------

Training in meeting the MH/DD/SAS needs		
of the consumer(s) based on diagnosis	_____	_____

Review Service Definition/Policy	_____	_____
----------------------------------	-------	-------

On-call schedule (if applicable)	_____	_____
----------------------------------	-------	-------

Administrative Assistant

Review appropriate Systems Protocols	_____	_____
--------------------------------------	-------	-------

Third Day

Training by licensed/certified contract trainer

CPR	_____	_____
-----	-------	-------

First Aid	_____	_____
-----------	-------	-------

Bloodborne Pathogens/OSHA	_____	_____
---------------------------	-------	-------

Fourth Day

Medication Administration	_____	_____
---------------------------	-------	-------

Fifth Day**Quality Management Director****Review of Incident Reporting Policy and forms**

Review of DMH rule (computer)

Review of Quality Improvement Policy

Review of current QI Plan

Training Director

Review process request for training and cost

Individual Training Plan Development

Sixth Day**Supervisor**

Introduction to Team

Shadowing

Over the next few weeks**Supervisor and/or Clinical Director**

Shadowing

45 Days after hire date**Training Director**

Monitoring of training

Supervisor

-Mid probation evaluation

90 Days after hire date**Training Director**

Evaluate training performance

Supervisor

End of probation evaluation

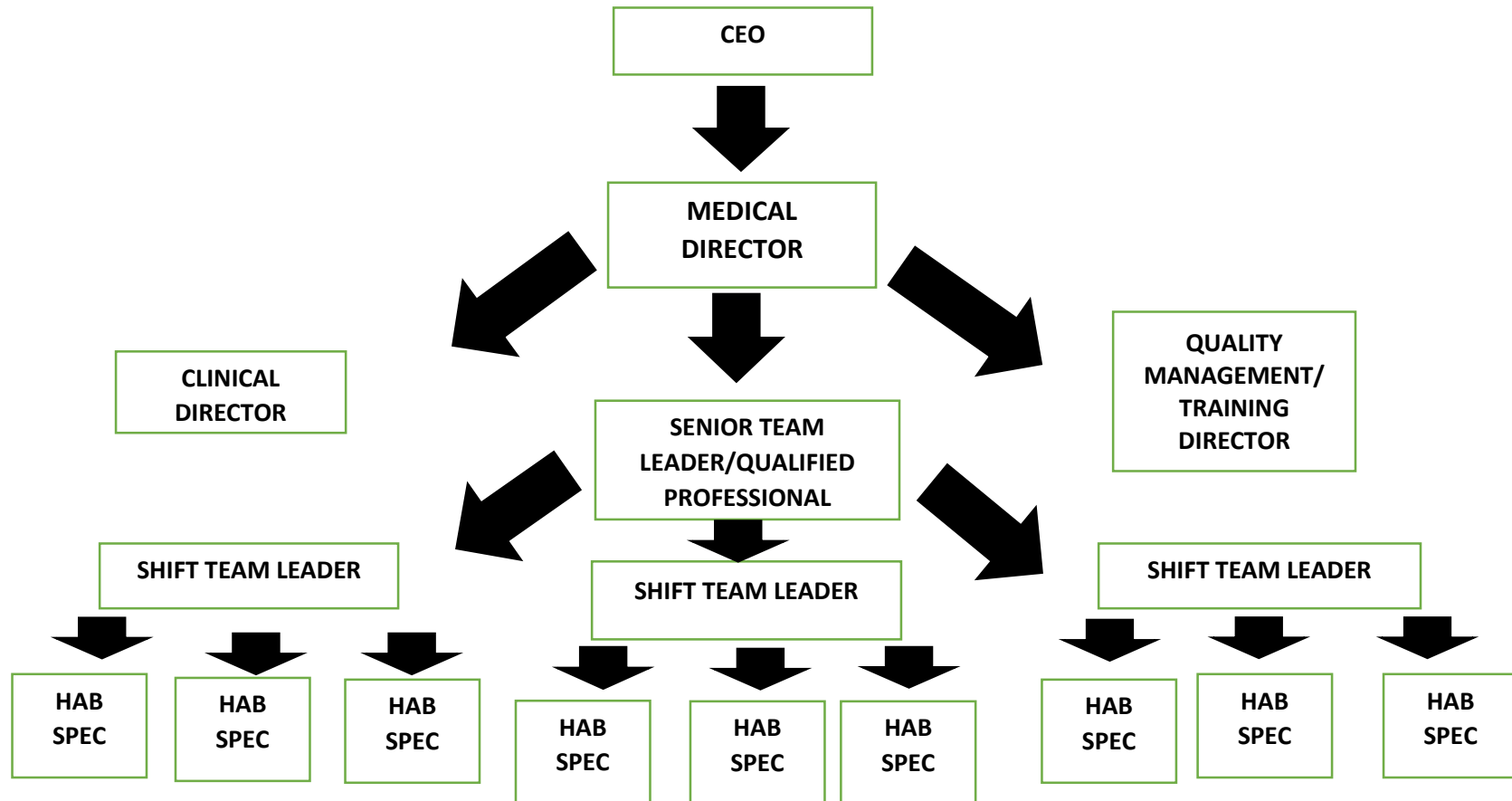
Key:

NH = New Horizon

Revised 4-29-2018

NEW HORIZON GROUP HOME, LLC

RESIDENTIAL SERVICES LEVEL IV



All Qualified Professionals to meet the needs of the consumers, including but not limited to, Psychologists, Psychiatrists, Social Workers, Medical Professionals, Educational and/or Vocational Licensed persons, etc will be via contract. All services will be conducted in a manner that is fully integrated into ongoing treatment and driven by the consumer's treatment plan.

New Horizons, LLC	Policy No.: S-10 B Page 1 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

Program Description

Residential Treatment Level IV is an intensive residential treatment facility that is a 24-hour residential facility which provides a structured living environment within a system of care approach for children or adolescents whose primary diagnosis is mental illness, severe emotional and behavioral disorders, or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. The needs of the children/adolescents require more intensive treatment and supervision than would be available in a residential treatment facility offering only a staff secure setting.

These consumers shall not meet the criteria for acute inpatient psychiatric services and require the following:

- Removal from home to an intensive integrated treatment setting; and
- Treatment in a locked setting.

Services shall be designed to:

- Assist in the development of symptom and behavior management skills;
- Include intensive, frequent, and pre-planned crisis management;
- Provide containment and safety from potentially harmful or destructive behaviors;
- Promote involvement in regular productive activity, such as school or work; and
- Support the consumer in gaining the skills needed for reintegration into community living.

The intensive residential treatment facility shall coordinate with other individuals and agencies within the consumer's system of care.

For Medicaid, the Residential Treatment-Secure is a service targeted to children under age 21, which offers a physically secure, locked environment in a highly structured and supervised program setting only, excluding room and board.

If a consumer has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer.

For NC Health Choice, the Residential Treatment-Secure is a service targeted to children under age 18, which offers a physically secure, locked environment in a highly structured and supervised program setting only, excluding room and board.

This service is responsive to the need for intensive, active therapeutic intervention, which requires a secure treatment setting to be successfully implemented.

This service provides the following activities under its core program:

New Horizons, LLC	Policy No.: S-10 B Page 2 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

- Medically supervised secure treatment interventions, which may include time-out room, passive restraints, etc.
- Structured programming/intervention to assist the consumer in acquiring control over acute behaviors, verbal aggression, depression, PTSD (post-traumatic stress disorder), etc.
- On-site consultation and supervision by psychologist or psychiatrists.

Provider Requirements and Supervision:

The minimal requirements are:

- a high school diploma or GED, associate degree with one year of experience, or
- a four-year degree in the human service field, or
- a combination of experience, skills, and competencies that is equivalent, plus:
- Skills and competencies of this service provider must be at a level that includes structured interventions in a contained setting to assist the consumer in acquiring control over acute behaviors.
- Sex Offender Specific Service Provision: In addition to the above, when the consumer requires sex offender specific treatment, as outlined in their treatment plan, special training of the caregiver is required in all aspects of sex offender specific treatment. Implementation of therapeutic gains is to be the goal of the placement setting.

AND

- Supervision is provided by a Qualified Professional with sex offender specific treatment expertise is on-site per shift.
- Must meet requirements established by state personnel system or equivalent for job classifications. Supervision provided by a qualified personnel as stated in 10 NCAC 27G rules regarding Professionals and Paraprofessionals.

Staffing Requirements:

Direct Care Staffing:

Residential Treatment Level IV requires a minimum of three direct care staff per six consumers; four direct care per seven, eight, or nine consumers; and five direct care staff per ten, eleven, or twelve consumers, at all times.

During consumer sleep hours, three direct care staff shall be present of which two shall be awake and the third may be asleep. In addition to the minimum number of direct care staff, more direct care staff may be required in the facility based on the consumer's individual needs as specified in the treatment plan.

New Horizons, LLC	Policy No.: S-10 B Page 3 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

Qualified Professional:

At least one full-time qualified professional, having at least two years of direct consumer care experience shall be employed to perform clinical and administrative responsibilities at a minimum of 40 hours each week; and 75% shall occur when consumers are awake and present in the facility. A Qualified Professional shall be available by telephone or page and shall be able to reach the facility within 30 minutes always.

The Qualified Professional is responsible for a minimum of the following:

- Management of the day to day operations of the facility;
- Supervision of paraprofessionals regarding responsibilities related to the implementation of each consumer's treatment plan;
- Participation in the treatment planning meetings; and
- Provision of basic case management functions.

Licensed Professional:

At least a full-time licensed professional, either fully licensed or provisional license issued by the governing board regulating a human service profession in NC. For substance related disorders this shall include a Licensed Clinical Addiction Specialist or a Certified Clinical Supervisor.

The Licensed Professional is responsible for minimum the clinical and administrative responsibilities of the following:

- Supervision of direct care staff;
- Oversight of emergencies;
- Provision of direct clinical psychoeducational services to the consumers or families;
- Participation in treatment planning meetings; and
- Coordination of each consumer's treatment plan.

Educational Services:

Educational services within the facility shall be arranged and designed to maintain the educational and intellectual development of the consumer. Treatment staff shall coordinate with the local education agency to ensure that the consumer needs are met as identified in the education plan. An Educational Plan (IEP) shall be developed for each of the consumers coordinated by the contract Education Service staff person and the local education agency.

This setting has a higher level of consultative and direct service from Licensed Qualified Professionals. Psychiatric consultation shall be available as needed for each consumer. Other licensed and/or certified professionals who may be involved with the service provision, depending on the consumer's needs include but not limited to: Psychologists, Social Workers, Medical Professionals, Educational and/or Vocational Licensed persons, etc. All relevant licensed services, except for the full-time Licensed Professional (LPC, in the context of the

New Horizons, LLC	Policy No.: S-10 B Page 4 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

residential treatment with meeting the needs of the consumers will be via an agency contract position rather than job description. All services will be conducted in a manner that is fully integrated into ongoing treatment and driven by the consumer's treatment plan.

Service Type/Setting:

Residential Treatment Level IV is a 24-hour service operating 24 hours per day, seven days per week, and each day of the year. It is provided in a facility program type setting. This service is billable to Medicaid. This service is licensed under 122-C. Program type (27G. 1800 Residential Treatment Secure). Each facility shall serve no more than 12 consumers.

Each consumer shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. Family members or other legally responsible persons shall be involved in development of plans to assure a smooth transition to a less restrictive setting.

Program Requirements:

Therapeutic Relationship/Cognitive/Behavioral Skill Acquisition:

Residential Treatment Level IV service provides school, psychological and psychiatric consultation, nurse practitioner, vocational training, recreational activity, and other relevant services in the context of the residential treatment. The treatment needs of the consumers are usually so extreme that these activities can only be provided in a therapeutic setting. As a result, the number of on-site interventions from qualified professionals, including psychologists and physicians are notably higher than less restrictive residential settings. Through the intensive therapeutic focus, the consumers are taught and assisted with acquiring management skills relevant to their specific disability symptoms. All services are conducted in a manner that is fully integrated into ongoing treatment.

Structure of Daily Living/ Program Type:

The service is provided in a structured program setting and staff is present and available always with constant supervision, including staff awake during consumer sleep hours. A minimum of two direct care staff is required per six beneficiaries always. In addition, consultative and treatment services at a qualified professional level are provided no less than eight hours per child per week. This staff time may be contributed by various qualified professional individuals with examples of: a social worker conducting group treatment or activity; behavioral management consultation being provided by a psychologist; or, a psychiatrist providing evaluation and treatment services. These services must be provided at the residential facility. Group therapy or activity time may be included as the total time per beneficiary. For example: if there are six consumers in a group for 90 minutes, this may be counted as 90 minutes per consumer. However, periodic services may not be used to augment residential services.

New Horizons, LLC	Policy No.: S-10 B Page 5 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

This service includes all Family/Program Residential Treatment - High Level III elements along with activities relevant to Residential Treatment Level IV. An inclusive listing of all Level III and Level IV activities is provided below:

1. Medically supervised secure structured therapeutic treatment environment including intensive and frequent crisis management with or without physical restraints and containment in time-out room designed to maximize the opportunity to improve and/or maintain the consumer's optimum level of functioning. Locked and secure to ensure safety for consumers who are involved in a wide range of dangerous behaviors which are manageable outside of the hospital setting.
2. Immediate staff support/supervision providing person directed and managed activities in all identified need areas, mentoring, modeling, positive reinforcement, redirection, de-escalation, guidance, etc., supervised recreational activities when used as a strategy to meet clinical goals, supervised community integration activities; and direct assistance with adaptive skills training.
3. Continual and intensive programmatic structure with specific interventions designed to address and assist the consumer in acquiring control over acute behavioral or substance use disorder treatment needs through supervised psychoeducational activities including the development and maintenance of daily living, anger management, social, family living, communication, and stress management skills, etc.
4. Consultation from psychiatrist/psychologist monthly. And
5. This service is to support the consumer in gaining the skills necessary to step down to a lower level of care.

Therapeutic Leave:

Each consumer is entitled to take up to 45 days of therapeutic leave in any calendar year (no more than 15 days within one calendar quarter-3 months).

Each of the below components are relevant to the therapeutic leave:

1. No more than five consecutive days may be taken without the approval of the consumer's treatment team.
2. The leave must be for therapeutic purposes only and must be agreed by the consumer's treatment team. The necessity and the expectations for the leave must be documented in the consumer's treatment plan and the therapeutic justification for each instance of the leave entered into the consumer's record which is maintained at the Residential Facility site.
3. Therapeutic leave shall be defined as the absence of a consumer from the residential facility overnight, with the expectation of return, to participate in a medically acceptable therapeutic facility as agreed upon by the treatment team and documented in the treatment plan.
4. New Horizon Group Home will reserve the consumer's bed while on therapeutic leave.

New Horizons, LLC	Policy No.: S-10 B Page 6 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

5. New Horizon Group Home will keep a cumulative record of therapeutic leave days taken by each consumer for reference and audit purposes. Consumers are considered on therapeutic leave according to the facility's midnight census.
6. The official record of therapeutic leave days take for each consumer shall be maintained by the State or it's agent.
7. Therapeutic leave is not applicable regarding cases when the therapeutic leave is for receiving inpatient services or any other Medicaid or NC Health Choice covered service or in another facility. Therapeutic leave cannot be paid when Medicaid or NC Health Choice is paying for any other 24-hour service.
8. Transportation from a facility to the therapeutic leave site is not considered to be an emergency; therefore, ambulance service for this purpose is not reimbursable.

Prior Approval Requirements:

For both Medicaid, State Funded, and NC Health Choice, the MCO/LME authorizes the admissions and completes concurrent utilization reviews. The admissions documentation and utilization reviews must be documented in the service record.

Medical Necessity:

A primary care physician, psychiatrist, or a licensed psychologist must order service. All service orders must be made prior to or on the day service is initiated, on the standardized service order form.

Entrance Criteria:

The consumer is eligible for this service when:

Consumer is medically stable but may need significant intervention to comply with medical treatment.

AND

The consumer's identified need cannot be met with Residential Treatment Level III service.

AND

The consumer is experiencing any one of the following (may be related to the presence of severe affective, cognitive, or behavioral problems or intellectuals/developmental delays/disabilities):

- a. Severe difficulty maintaining in the naturally available family setting or lower level of treatment as evidenced by, but not limited to:
 1. Frequent and severe conflict in the setting; OR
 2. Frequently and severely limited acceptance of behavioral expectations and other structure; OR

New Horizons, LLC	Policy No.: S-10 B Page 7 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

3. Frequently and severely limited involvement in support or impaired ability to form trusting relationships, with caretakers; OR
4. A pervasive and severe inability to form trusting relationships with caretakers or family members; OR
5. An inability to consider the effect of inappropriate personal conduct on others.
- b. Frequent physical aggression including severe property damage or moderate to severe aggression toward self or others.
- c. Severe functional problems in school or vocational setting or other community setting as evidence by:
 1. Failure in school or vocational setting because of frequent and severely disruptive behavioral problems in school or vocational setting; OR
 2. Frequent and severely disruptive difficulty in maintaining appropriate conduct in community settings; OR
 3. Severe and pervasive inability to accept age appropriate direction and supervision from caretakers or family members couple with involvement in potentially life-threatening high-risk behaviors.
- d. Medication administration and monitoring has alleviated some symptoms, but other treatment interventions are needed to control severe symptoms.
- e. Experiences significant limitations in ability to independently access or participate in other human services and requires intensive, active support and supervision to stay involved in other services.
- f. Has significant deficits in ability to manage personal health, welfare, and safety without intense support and supervision.
- g. For consumers identified with or at risk for inappropriate sexual behavior;
 1. The parent/caregiver is unable to provide the supervision of the sex offender required for community safety.
 2. Moderate to high risk for re-offending.
 3. Moderate to high risk for sexually victimizing others.
 4. Deficits that put the community at risk for victimization unless specifically treated for sexual aggression problems.
 5. A Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and a Checklist for Risk Assessment of Adolescent Sex Offenders.

Continued Stay Criteria:

The desired outcome or level of functioning has not been restored, improved, or sustained over the period outlined in the consumer's service plan or the consumer continues to be at risk for

New Horizons, LLC	Policy No.: S-10 B Page 8 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

relapse based on history or the weak nature of the functional gains, or any one of the following apply:

- a. Consumer has achieved initial service plan goals and additional goals are indicated.
- b. Consumer is making satisfactory progress toward meeting goals.
- c. Consumer is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains which are consistent with the consumer's pre-morbid level of functioning, are possible or can be achieved.
- d. Consumer is not making progress; the service plan must be modified to identify more effective interventions.
- e. Consumer is regressing; the service plan must be modified to identify more effective interventions.

AND

The statewide vendor authorizes admission and conducts concurrent utilization reviews. Utilization review must be documented in the service record.

Discharge Criteria:

The consumer shall be discharged from this level of care if any one of the following is true:

- a. The level of functioning has improved with respect to the goals outlined in the service plan and the consumer can reasonably be expected to maintain these gains at a lower level of treatment.

OR

- b. The consumer no longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

OR

- c. Discharge or step-down services can be considered when in a less restrictive environment the safety of the consumer around sexual behavior and the safety of the community can reasonably be assured.

Any denial, reduction, suspension, or termination of services requires notification to the consumer and legal guardian about their appeal rights.

Emergency Discharge Criteria:

A consumer shall not be discharged or transferred from the facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person.

The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other

New Horizons, LLC	Policy No.: S-10 B Page 9 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility.

In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency is stabilized.

In case of an emergency, notification may be by telephone. A service planning meeting as set forth in shall be held within five business days of an emergency transfer or discharge.

Service Maintenance Criteria:

If the consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service shall be maintained when it can be reasonable anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

- There is history of regression in the absence of residential treatment or a lower level of residential treatment.
- There are current indications that the consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.
- In the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains the presence of a DSM-5, or any subsequent editions of this reference material, diagnosis would necessitate a disability management approach.

Expected Outcomes: This service includes interventions that address the functional problems associated with complex and/or complicated conditions of the identified population. These interventions are strength based and focused on promoting symptom stability, increasing coping skills and achievement of the highest level of functioning in the community.

Documentation Requirements:

Documentation in the consumer's medical record is required as defined in the Service Records Manual APSM 45-2.

The minimum documentation standard is a full service note per shift on the standardized service note form. The documentation of interventions and activities is directly related to the consumer's:

- Identified needs,
- Preferences or choices,

New Horizons, LLC	Policy No.: S-10 B Page 10 of 10
Subject: Residential Treatment Level IV/Secure	Effective Date: 05-30-17
	Revised Date: 5-02-18

- c. Specific goals, services, and interventions, and
- d. Frequency of the service which assists in restoring, improving, or maintaining their level of functioning.
- e. Documentation of critical events, significant events or changes in status during treatment shall be evidenced in the consumer's medical record as appropriate.
- f. Sex Offender Specific Service Provision: Documentation includes the specific goals of sex offender treatment as supported and carried out through the therapeutic setting and interventions outlined in the service plan.

Service Exclusions:

Residential Treatment Level IV does not include and cannot be provided during the same authorization period as the following:

- Activities provided by Medicaid or Health Choice funded residential programs: acute hospitalization programs: acute hospitalization, ICF-MR, rehabilitation facilities, and nursing facilities for medically fragile children, etc.
- Child care facilities which cannot meet mental health licensure and standards.
- Foster care
- Run-away shelters
- Respite providers
- Summer recreation camps
- Periodic services may not be used to augment residential services.

New Horizons, LLC	Policy No.: C-11 Page 1 of 6
Subject: Restrictive Interventions	Effective Date: 01/01/09
	Revised Date: 2/5/13; 7/24/15; 2/28/18

Policy

All treatment and habilitation are provided to consumers using the least restrictive, most appropriate, and effective positive treatment modalities possible. Restrictive interventions are not employed as a means of coercion, punishment, or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions are not used in a manner that causes harm or abuse.

Restrictive intervention is employed as the last resort and will only be employed if the consumer is in immediate danger of harming self or others.

The only permitted restrictive intervention allowed by staff of New Horizons, LLC is relevant to the residential services.

The following outlines the permitted restraints for each residential level:

- Residential Level III: physical restraint will only be employed if the consumer is in immediate danger of harming self or others;
- Residential Level IV: physical restraint will only be employed if the consumer is in immediate danger of harming self or others. Time-out and Isolation is not used as a behavior modification.

Procedures

1. The Clinical Review Team reviews all Comprehensive Clinical Assessments of potential consumers being recommended for service. The review of the assessment includes appropriateness of the service as well as a review of the medical history to determine whether a possible emergency administered restraint can be completed without risk to the health and safety of the consumer.
2. All staff provide a positive environment that promotes adaptive behaviors. Positive alternatives and less restrictive interventions are considered and are used whenever possible prior to the use of more restrictive interventions.
3. The use of restrictive interventions is limited to:
 - a. emergency situations, in order to terminate a behavior or action, in which a consumer is in imminent danger of abuse or injury to self or other persons or when substantial property damage is occurring that poses imminent danger of injury or harm to self or others.

New Horizons, LLC	Policy No.: C-11 Page 1 of 6
Subject: Restrictive Interventions	Effective Date: 01/01/09
	Revised Date: 2/5/13; 7/24/15; 2/28/18

4. All staff that provides direct care to consumers must successfully pass a DHHS approved alternative intervention curriculum prior to working alone with a consumer.
5. In the event a restrictive intervention is warranted to avoid injury, parameters have been established. The CEO or designee is responsible for reviewing the use of restrictive interventions and for ensuring all requirements are met and adhered.
6. Staff give consideration to the individual's physical and psychological well-being before, during and after utilization of a restrictive intervention, including:
 - a. Review of the consumer's health history or the comprehensive health assessment conducted upon admission to a service. The health history or comprehensive health assessment includes the identification of pre-existing medical conditions or any disabilities and limitations that would place the consumer at greater risk during the use of restrictive interventions;
 - b. Continuous assessment and monitoring of the physical and psychological well-being of the resident and the safe use of physical restraint throughout the duration of the restrictive intervention by a staff who is physically present and trained in the use of emergency safety interventions;
 - c. Continuous monitoring by staff trained in the use of cardiopulmonary resuscitation of the individual's physical and psychological well-being during the use of manual restraint; and
 - d. Continued monitoring by staff trained in the use of cardiopulmonary resuscitation of the consumer's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention.
7. Following the utilization of a restrictive intervention, the staff member who utilized the restrictive intervention conducts debriefing and planning with the individual and the legally responsible person, if applicable, to eliminate or reduce the probability of the future use of restrictive interventions. Debriefing and planning is conducted, as appropriate, to the level of cognitive functioning of the individual consumer.
8. It is the duty and responsibility of all staff to ensure the proper use and documentation of restrictive interventions. The staff member using the restrictive intervention has responsibility for its documentation and notification

New Horizons, LLC	Policy No.: C-11 Page 1 of 6
Subject: Restrictive Interventions	Effective Date: 01/01/09
	Revised Date: 2/5/13; 7/24/15; 2/28/18

of others that a restrictive intervention has been used. That staff member is also responsible for checking the consumer's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, documentation if a consumer has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and the identification and documentation of alternative emergency procedures, if needed.

9. The emergency use of restrictive interventions shall be limited, as follows:
 - a. Documentation demonstrates that less restrictive intervention techniques were used prior to the use of restraint;
 - b. staff approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization;
 - c. the continued use of such interventions is authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training;
 - d. the responsible professional meets with and conducts an assessment that includes the physical and psychological well-being of the consumer and writes a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the consumer, but concurs that the intervention is justified after discussion with the staff, continuation of the intervention may be verbally authorized until an on-site assessment of the consumer can be made;
 - e. a verbal authorization does not exceed three hours after the time of initial employment of the intervention;
 - f. each written order for physical restraint can only be completed by a designated, qualified and competent licensed physician or licensed independent practitioner. The physician or practitioner must complete a face-to-face evaluation of the person served within one hour of the order for physical restraint; and
 - g. the order for restraint is time limited and does not exceed four hours for adult consumers and one hour for adolescents and/or children. The original order is only renewed in accordance with these limits or up to a total of 24 hours.

10. The following precautions and actions are employed whenever a consumer is in physical restraint:

New Horizons, LLC	Policy No.: C-11 Page 1 of 6
Subject: Restrictive Interventions	Effective Date: 01/01/09
	Revised Date: 2/5/13; 7/24/15; 2/28/18

- a. when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the consumer occurs at least every 15 minutes, or more often as necessary, to assure the safety of the consumer, attention is paid to the provision of regular meals, bathing and the use of the toilet; and such observation and attention are documented in the consumer record; and
 - b. consumers may be subject to injury: staff remains present with the consumer continuously.
11. The use of a restrictive intervention is discontinued immediately at any indication of risk to the consumer's health or safety or immediately after the consumer gains behavioral control. If the consumer is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained.
12. The written approval of the CEO or designee is required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified above.
13. Standing orders or PRN orders are not used to authorize the use of physical restraint.
14. The use of a restrictive intervention is considered a restriction of the consumer's rights and complies with documentation requirements in these policies and procedures, which comply with GS 122C-62(e).
15. When any restrictive intervention is utilized for a consumer, notification of others occurs as follows:
 - a. those to be notified as soon as possible but within 24 hours of the next working day, to include: the treatment or habilitation team, or its designee as determined by the team, after each use of the intervention; and the staff member who serves on the Human Rights Committee; and
 - b. the legally responsible person of a minor is notified immediately unless she/he has requested not to be notified.
16. The agency conducts reviews and reports on any and all use of restrictive interventions, including:

New Horizons, LLC	Policy No.: C-11 Page 1 of 6
Subject: Restrictive Interventions	Effective Date: 01/01/09
	Revised Date: 2/5/13; 7/24/15; 2/28/18

- a. a regular review by a designee appointed by the CEO who serves on the Human Rights Committee, and review by the Human Rights Committee, in compliance with confidentiality rules 10 NCAC 28A;
 - b. an investigation of any unusual or possibly unwarranted patterns of utilization; and
 - c. documentation of the following is maintained on a log:
 - name of the consumer;
 - name of the responsible professional;
 - date of each intervention;
 - time of each intervention;
 - type of intervention;
 - duration of each intervention;
 - reason for use of the intervention;
 - positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used;
 - debriefing and planning conducted with the consumer, legally responsible person, if applicable, and staff, to eliminate or reduce the probability of the future use of restrictive interventions; and
 - negative effects of the restrictive intervention, if any, on the physical and psychological well being of the consumer.
17. The CEO or designee ensures that data on the use of physical restraint is collected and analyzed. The data collected and analyzed reflects for each incident:
- a. the type of procedure used and the length of time employed;
 - b. alternatives considered or employed; and
 - c. the effectiveness of the procedure or alternative employed.
18. The data is analyzed on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. Data is made available to the Secretary of DHHS upon request and to the local LME/MCO's. (Rules, policies and procedures do not prohibit the use of "voluntary restrictive interventions", but is doubtful that a consumer will volunteer for physical restraint. If it did occur, the same policies and procedures would apply.)
19. Restrictive interventions are not permitted in some of the agency's services. Staff always follows the consumer's Crisis Plan. For those specified areas/services, in the event that a consumer's behavior is dangerous to

New Horizons, LLC	Policy No.: C-11 Page 1 of 6
Subject: Restrictive Interventions	Effective Date: 01/01/09
	Revised Date: 2/5/13; 7/24/15; 2/28/18

themselves or others and cannot be redirected, staff use “natural consequences”, as appropriate, and call 911 for assistance if necessary.

20. Any violation by staff of consumer rights, including 10 NCAC 27D .0304, is grounds for dismissal of the staff member.
- the decision to continue the specific intervention is based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed.

Planned Intervention

Planned interventions are not employed by the agency staff.

Documentation

- Whenever an unplanned emergency restrictive intervention is utilized, documentation made in the consumer record includes, at a minimum:
 - Notation of the consumer's physical and psychological well-being;
 - Notation of the frequency, intensity, and duration of the behavior which led to the intervention, and any precipitating circumstances contributing to the onset of the behavior;
 - The rationale for the use of the intervention, the positive or less restrictive intervention considered and used and the inadequacy of less restrictive intervention techniques that were used;
 - A description of the intervention and the date, time, and duration of its use;
 - A description of accompanying positive methods of intervention;
 - A description of the debriefing and planning with the consumer and the legally responsible person, if applicable, for the emergency use of restraint to eliminate or reduce the probability of the future use of interventions;
 - A description of the debriefing and planning with the consumer and the legally responsible person, if applicable, for the planned use of restraint if determined to be clinically necessary; and
 - Signature and title of the staff member who initiated, and of the staff member who further authorized the use of the intervention.

Definition

Restrictive Interventions: Defined as use of therapeutic holds/maneuvers exceeding 15 minutes of duration. (specific holds taught in the curriculum approved by DHHS)

New Horizon Group Home, LLC

Quarterly Health Safety Checklist

Safety Checklist 2018	
Ensure that sinks, toilets, doors, windows and chairs are in working order	
Ensure air vents are uncovered and that filters are not due for replacement. (Schedule replacement as necessary)	
Check locks and alarm system. Enable doors and windows and motions. Disable using your pin. Ensure the system reports when front door is open. Are functions in good working order?	
Ensure that there are no frayed electrical cords or overloaded outlets, and that outlets and light switches are working properly.	
Ensure that there are no pest problems or plan and schedule pest control.	
Locate flashlight and batteries in emergency kit. Are they stocked?	
Locate and test smoke detectors. Replace batteries at least 1xyear.	
Ensure that no hazardous chemical or bio-hazardous materials are on the premises.	
Ensure that all walkways and fire exits are free of wires, unrolled carpet, broken tile, and any other potential trip hazards.	
Locate and ensure that there is an Emergency Number list and a Bomb Threat Sheet by each phone	
Locate Evacuation Routes and Procedures (posted) and ensure they are intact. Replace, if necessary	
Ensure that first Aid Kits are in place and stocked according to Evacuation Route:	
Locate all fire extinguishers on evacuation plan (posted) and check each using 10-point inspection: 1- There are no broken or missing safety seals; 2- There is no evidence of physical damage (cracking), corrosion, leakage or clogged nozzle; 3- Pressure gauge readings are in the proper range or position (green area); 4- Operating instructions are legible and facing outward; 5- Safety pin is in place; 6- Fullness is ensured by shaking the extinguisher; 7- Turn the fire extinguisher upside down and rotate in a circle a few times to ensure powder does not settle at bottom; 8- Hydrostatic date is within 3 years; 9- Name and address of inspector are present and legible; 10- The fire extinguisher is returned to the proper location.	
Other: Ensure that the facility overall is representative of a safe facility, with no obvious potential hazards.	
Emergency information for each employee and consumer is in current	
Furnishings: check for evidence of needed repair/replacement; Linens: clean and evidence of extra supply in storage closet Emergency Supplies: evidence of supplies according to the agency's EOP	

New Horizons, LLC	Policy No.: C-9 Page 1 of 2
Subject: Search and Seizure	Effective Date: 01/01/09
	Revised Date: 5-03-18

Policy

New Horizons, LLC ensures that each consumer receiving services from New Horizons, LLC is free from unwarranted invasion of privacy.

Procedures

1. Consumers and/or guardians are told at time of admission of their rights regarding search and seizure and specific articles or substances that are not allowed. The following items are not permitted on the premises of any office or person: fire arms (unless carried by law enforcement), fire works, stolen goods, illegal drugs, or alcohol. Notice of prohibition is documented in rules provided to consumers.
2. Employees do not search consumers receiving community periodic services, e.g. Intensive-In Home, or a person's home or property.
3. All consumers are asked to voluntarily forfeit or dispose of any illegal or dangerous items. If there is reasonable cause to suspect danger, staff contact law enforcement. Situations justifying this may include but are not limited to the following:
 - drug abuse,
 - possession of dangerous articles (i.e. clubs, swords, fire arms, fire works, etc.), and
 - possession of stolen property that has been witnessed by an employee or reliable informant, or is clearly indicated by surrounding circumstances, such as a prior history of similar behavior, and opportunity or accessibility beyond that of other consumers exists.
4. If staff have information that a residential service recipient has dangerous or illegal property, and the person refuses to voluntarily forfeit the property, staff may search the person's belongings. At no time will a strip search occur. If staff feels it is necessary to search a person's body, there must be at least two staff involved with the search and one of the same sex as the person being searched. Any search must be conducted in a manner that is respectful to the person searched. Any confiscated substances are returned the rightful owner, given to the legal guardian, or give to the Director for action, e.g. to give to law enforcement.
5. All search and seizure activities by law enforcement or staff are documented on the Search and Seizure Report and IRIS Incident Reporting System, and include:

New Horizons, LLC	Policy No.: C-9 Page 2 of 2
Subject: Search and Seizure	Effective Date: 01/01/09
	Revised Date: 5-03-18

- a. scope of search;
- b. reason for search;
- c. procedures followed in the search;
- d. a description of any property seized; and
- e. an account of the disposition of seized property.

All reporting timelines relevant to Search and Seizures, reflected in the DMH Incident Reporting Manual, must be adhered.

North Carolina Interventions

*Agency is responsible for verifying Instructor certification.
Go to DMH/DD/SAS website:
<http://www.ncdmh.net/NCI-Public/index.htm>*

NC Participant

This certifies that

Monty Little

*has fulfilled all requirements for certification and, subject to
annual recertification, is qualified to use physical technique NCI Interventions – Core + Training
(Parts A and B + designated optional techniques)*

This individual is certified in 13 optional techniques (see back)

A curriculum of the NC Division of Mental Health, Development Disabilities and Substance Abuse Services

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Instructor signatures

4/14/2018

Date

Certificate is valid through 4/2019

Monday 11:41e
By Kelly
4-14-18

BLOCKS:

- ☒ Kick block – Method A
- ☒ Kick block – Method B

THERAPEUTIC HOLDS:

- ☒ Overhead (A)
- ☒ Overhead (B)
- ☒ Hook (A)
- ☒ Hook (B)
- ☒ Straight (A)
- ☒ Straight (B)
- ☒ Uppercut
- ☒ Kick (A)
- ☒ Therapeutic wrap

RELEASES:

- ☒ Two-handed hair pull – front
- ☒ Two-handed hair pull – back
- ☒ One-handed hair pull assist
- ☒ Two-handed hair pull assist

- ☐ Optional bite release
- ☐ Bite release (assist)
- ☐ Back choke (bend)
- ☐ Bear hug (bicep release)

TRANSPORTS:

- ☒ Limited control walk
- ☐ Modified limited control walk (from standing position)
- ☐ Modified limited control walk (from floor)
- ☐ One person therapeutic walk
- ☐ Two person therapeutic walk
- ☐ Escape attempt
- ☐ Therapeutic walk to chair
- ☐ Therapeutic hold in chair with assistance

CARRIES:

- ☐ Two person therapeutic carry
- ☐ Three person therapeutic carry (standing)
- ☐ Three person therapeutic carry (from floor)
- ☐ Four-Five person carry (optional)

North Carolina Interventions

*Agency is responsible for verifying Instructor certification.
Go to DMHF/DD/SAS website:
<http://www.ncdmh.net/NCI-Public/index.htm>*

NC Participant

This certifies that

Jacqualine Cagle

*has fulfilled all requirements for certification and, subject to
annual recertification, is qualified to use physical technique NCI Interventions – Core + Training
(Parts A and B + designated optional techniques)*

This individual is certified in 13 optional techniques (see back)

A curriculum of the NC Division of Mental Health, Development Disabilities and Substance Abuse Services

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Instructor signatures

4/14/2018

Date

Certificate is valid through 4/2019

BLOCKS:

☒ Kick block – Method A

☒ Kick block – Method B

THERAPEUTIC HOLDS:

☒ Overhead (A)

☒ Overhead (B)

☒ Hook (A)

☒ Hook (B)

☒ Straight (A)

☒ Straight (B)

☒ Uppercut

☒ Kick (A)

☒ Therapeutic wrap

RELEASES:

☒ Two-handed hair pull – front

☒ Two-handed hair pull – back

☒ One-handed hair pull assist

☒ Two-handed hair pull assist

☐ Optional bite release

☐ Bite release (assist)

☐ Back choke (bend)

☐ Bear hug (bicep release)

TRANSPORTS:

☒ Limited control walk

☐ Modified limited control walk (from standing position)

☐ Modified limited control walk (from floor)

☐ One person therapeutic walk

☐ Two person therapeutic walk

☐ Escape attempt

☐ Therapeutic walk to chair

☐ Therapeutic hold in chair with assistance

CARRIES:

☐ Two person therapeutic carry

☐ Three person therapeutic carry (standing)

☐ Three person therapeutic carry (from floor)

☐ Four-Five person carry (optional)

*Jacqueline Pagle
By Kelly
4-14-18*

North Carolina Interventions

*Agency is responsible for verifying Instructor certification.
Go to DMH/DD/SAS website:
<http://www.ncdmh.net/NCI-Public/index.htm>*

NC Participant

This certifies that

Walter McKoy

*has fulfilled all requirements for certification and, subject to
annual recertification, is qualified to use physical technique NCI Interventions – Core + Training
(Parts A and B + designated optional techniques)*

This individual is certified in 13 optional techniques (see back)

A curriculum of the NC Division of Mental Health, Development Disabilities and Substance Abuse Services

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Bryan Holliday LCSW, LCAS, CCS, CSOTS 4/14/2018
Instructor signatures Date

Certificate is valid through 4/2019

BLOCKS:

- ☐ Kick block – Method A
- ☒ Kick block – Method B

THERAPEUTIC HOLDS:

- ☒ Overhead (A)
- ☐ Overhead (B)
- ☒ Hook (A)
- ☒ Hook (B)
- ☒ Straight (A)
- ☒ Straight (B)
- ☐ Uppercut
- ☐ Kick (A)
- ☒ Therapeutic wrap

RELEASES:

- ☒ Two-handed hair pull – front
- ☒ Two-handed hair pull – back
- ☐ One-handed hair pull assist
- ☐ Two-handed hair pull assist

Walter M. Hogg
By Hogg
4-14-18

- ☐ Optional bite release
- ☐ Bite release (assist)
- ☐ Back choke (bend)
- ☐ Bear hug (bicep release)

TRANSPORTS:

- ☒ Limited control walk
- ☐ Modified limited control walk (from standing position)
- ☐ Modified limited control walk (from floor)
- ☐ One person therapeutic walk
- ☐ Two person therapeutic walk
- ☐ Escape attempt
- ☐ Therapeutic walk to chair
- ☐ Therapeutic hold in chair with assistance

CARRIES:

- ☐ Two person therapeutic carry
- ☐ Three person therapeutic carry (standing)
- ☐ Three person therapeutic carry (from floor)
- ☐ Four-Five person carry (optional)

North Carolina Interventions

*Agency is responsible for verifying Instructor certification.
Go to DMHF/DD/SAS website:
<http://www.ncdmh.net/NCI-Public/index.htm>*

NC Participant

This certifies that

Sean Evans

*has fulfilled all requirements for certification and, subject to
annual recertification, is qualified to use physical technique NCI Interventions – Core + Training
(Parts A and B + designated optional techniques)*

This individual is certified in 13 optional techniques (see back)

A curriculum of the NC Division of Mental Health, Development Disabilities and Substance Abuse Services

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Bry Holliday LCSW, LCAS, CCS, CSOTS 4/14/2018
Instructor signatures Date

Certificate is valid through 4/2019

BLOCKS:

- ☒ Kick block – Method A
- ☒ Kick block – Method B

THERAPEUTIC HOLDS:

- ☒ Overhead (A)
- ☒ Overhead (B)
- ☒ Hook (A)
- ☒ Hook (B)
- ☒ Straight (A)
- ☒ Straight (B)
- ☒ Uppercut
- ☒ Kick (A)
- ☒ Therapeutic wrap

RELEASES:

- ☒ Two-handed hair pull – front
- ☒ Two-handed hair pull – back
- ☒ One-handed hair pull assist
- ☒ Two-handed hair pull assist

Sean Evans
Ray Kelly
4-14-18

- ☐ Optional bite release
- ☐ Bite release (assist)
- ☐ Back choke (bend)
- ☐ Bear hug (bicep release)

TRANSPORTS:

- ☒ Limited control walk
- ☐ Modified limited control walk (from standing position)
- ☐ Modified limited control walk (from floor)
- ☐ One person therapeutic walk
- ☐ Two person therapeutic walk
- ☐ Escape attempt
- ☐ Therapeutic walk to chair
- ☐ Therapeutic hold in chair with assistance

CARRIES:

- ☐ Two person therapeutic carry
- ☐ Three person therapeutic carry (standing)
- ☐ Three person therapeutic carry (from floor)
- ☐ Four-Five person carry (optional)

North Carolina Interventions

Agency is responsible for verifying participant compliance
Go to www.ncdhs.gov website
<http://www.ncdhs.gov/ncdhs/ncdhs/ncdhs.htm>

Participant

This certifies that

Richard Clanton

has fulfilled all requirements for certification and subject to
annual recertification + qualified to use physical techniques of interventions - (see - Training
Steps 1 and 2 - description optional techniques)

This individual is certified to 1 optional technique (see back)

A representative of the NC Division of Mental Health Developmental Disabilities and Substance Abuse Services

Bryan Pennington (CSW, LCA, CCS, CSO, TS)

By *Bryan Pennington* on 04/04/2018

Individual signature

Date

Certificate is valid through 04/04/2019

Richard Clewton
By Mallett
4-14-18

BLOCKS:

- ☒ Kick block – Method A
- ☐ Kick block – Method B

THERAPEUTIC HOLDS:

- ☒ Overhead (A)
- ☒ Overhead (B)
- ☒ Hook (A)
- ☒ Hook (B)
- ☒ Straight (A)
- ☒ Straight (B)
- ☒ Uppercut
- ☐ Kick (A)
- ☒ Therapeutic wrap

RELEASES:

- ☒ Two-handed hair pull – front
- ☒ Two-handed hair pull – back
- ☐ One-handed hair pull assist
- ☐ Two-handed hair pull assist

- ☐ Optional bite release
- ☐ Bite release (assist)
- ☐ Back choke (bend)
- ☐ Bear hug (bicep release)

TRANSPORTS:

- ☒ Limited control walk
- ☐ Modified limited control walk (from standing position)
- ☐ Modified limited control walk (from floor)
- ☐ One person therapeutic walk
- ☐ Two person therapeutic walk
- ☐ Escape attempt
- ☐ Therapeutic walk to chair
- ☐ Therapeutic hold in chair with assistance

CARRIES:

- ☐ Two person therapeutic carry
- ☐ Three person therapeutic carry (standing)
- ☐ Three person therapeutic carry (from floor)
- ☐ Four-Five person carry (optional)

North Carolina Interventions

*Agency is responsible for verifying Instructor certification.
Go to DMH/DD/SAS website:
<http://www.ncdmh.net/NCI-Public/index.htm>*

NC Participant

This certifies that

Melba Conley

*has fulfilled all requirements for certification and, subject to
annual recertification, is qualified to use physical technique NCI Interventions – Core + Training
(Parts A and B + designated optional techniques)*

This individual is certified in 13 optional techniques (see back)

A curriculum of the NC Division of Mental Health, Development Disabilities and Substance Abuse Services

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Bryan Holliday LCSW, LCAS, CCS, CSOTS 4/14/2018
Instructor signatures Date

Certificate is valid through 4/2019

North Carolina Interventions

*Agency is responsible for verifying Instructor certification.
Go to DMH/DD/SAS website:
<http://www.ncdmh.net/NCI-Public/index.htm>*

NC Participant

This certifies that

Melba Conley

*has fulfilled all requirements for certification and, subject to
annual recertification, is qualified to use physical technique NCI Interventions – Core + Training
(Parts A and B + designated optional techniques)
This individual is certified in 13 optional techniques (see back)*

A curriculum of the NC Division of Mental Health, Development Disabilities and Substance Abuse Services

Bryan Holliday LCSW, LCAS, CCS, CSOTS

By *Bryan Holliday* LCSW, LCAS, CCS, CSOTS 4/14/2018

Instructor signatures Date

Certificate is valid through 4/2019

BLOCKS:

- ☒ Kick block – Method A
- ☒ Kick block – Method B

THERAPEUTIC HOLDS:

- ☒ Overhead (A)
- ☒ Overhead (B)
- ☒ Hook (A)
- ☒ Hook (B)
- ☒ Straight (A)
- ☒ Straight (B)
- ☒ Uppercut
- ☒ Kick (A)
- ☒ Therapeutic wrap

RELEASES:

- ☒ Two-handed hair pull – front
- ☒ Two-handed hair pull – back
- ☒ One-handed hair pull assist
- ☒ Two-handed hair pull assist

Melba Conley
By Holly
4-14-2018

- ☐ Optional bite release
- ☐ Bite release (assist)
- ☐ Back choke (bend)
- ☐ Bear hug (bicep release)

TRANSPORTS:

- ☒ Limited control walk
- ☐ Modified limited control walk (from standing position)
- ☐ Modified limited control walk (from floor)
- ☐ One person therapeutic walk
- ☐ Two person therapeutic walk
- ☐ Escape attempt
- ☐ Therapeutic walk to chair
- ☐ Therapeutic hold in chair with assistance

CARRIES:

- ☐ Two person therapeutic carry
- ☐ Three person therapeutic carry (standing)
- ☐ Three person therapeutic carry (from floor)
- ☐ Four-Five person carry (optional)

North Carolina Interventions

*Agency is responsible for verifying Instructor certification.
Go to DMH/DD/SAS website:*

<http://www.ncdmh.net/NCI-Public/index.htm>

NC Participant

This certifies that

Cleveland Keaton

*has fulfilled all requirements for certification and, subject to
annual recertification, is qualified to use physical technique NCI Interventions – Core + Training
(Parts A and B + designated optional techniques)*

This individual is certified in 13 optional techniques (see back)

A curriculum of the NC Division of Mental Health, Development Disabilities and Substance Abuse Services

Bryan Holliday LCSW, LCAS, CCS, CSOTS

Bryan Holliday LCSW, LCAS, CCS, CSOTS 4/14/2018
Instructor signatures Date

Certificate is valid through 4/2019

BLOCKS:

- ☒ Kick block – Method A
- ☒ Kick block – Method B

THERAPEUTIC HOLDS:

- ☒ Overhead (A)
- ☒ Overhead (B)
- ☒ Hook (A)
- ☒ Hook (B)
- ☒ Straight (A)
- ☒ Straight (B)
- ☒ Uppercut
- ☒ Kick (A)
- ☒ Therapeutic wrap

RELEASES:

- ☒ Two-handed hair pull – front
- ☒ Two-handed hair pull – back
- ☒ One-handed hair pull assist
- ☒ Two-handed hair pull assist

Optional bite release

- ☒ Bite release (assist)
- ☒ Back choke (bend)
- ☒ Bear hug (bicep release)

TRANSPORTS:

- ☒ Limited control walk
- ☒ Modified limited control walk (from standing position)
- ☒ Modified limited control walk (from floor)
- ☒ One person therapeutic walk
- ☒ Two person therapeutic walk
- ☒ Escape attempt
- ☒ Therapeutic walk to chair
- ☒ Therapeutic hold in chair with assistance

CARRIES:

- ☒ Two person therapeutic carry
- ☒ Three person therapeutic carry (standing)
- ☒ Three person therapeutic carry (from floor)
- ☒ Four-Five person carry (optional)

Cleveland Heaton
By Kelly
4-14-18

Client Daily Activity Schedule

Monday-Thursday

7:05 am-8:00am	Wake-up, Dress, Wellness(morning exercise)
8:05 am-8:40am	Personal Hygiene, morning chores
8:45 am-9:05 am	Breakfast
9:05 am-9:30 am	Group Discussion
9:30 am-11:00 am	Education
11:05 am-12:00 pm	Educational Exploratory(could include educational films, tv programs, etc.)
12:05 pm-12:35 pm	Lunch
12:35 pm-12:55 pm	Arts and Crafts
1:00 pm-2:00 pm	Education
2:05 pm-2:45 pm	Drop Everything and Read
2:50 pm -3:25 pm	Individual Choice/Free Time
3:30 pm-4:35 pm	Quiet Time(includes individual snack)
4:35 pm-5:00 pm	Group Discussion
5:05 pm-5:55 pm	Study Hall(Client phone calls also take place during this time)
5:55 pm-6:30 pm	Dinner
6:30 pm-7:25 pm	Indoor/Outdoor Recreational Activities
7:30 pm-8:00 pm	Self Reflection
8:00 pm-8:15 pm	Snack
8:15 pm-8:45 pm	Bedtime Preparation
	Bedtime *Consumers are required to retire to their rooms at this time. They may engage in quiet activities in their room if they choose not to go to sleep immediately*
9:00 PM	
*9:30 am-5:00 pm	Clients will attend individual, substance abuse, or special diagnosis therapy
	Medication Management weekly
	At least two group discussions per week are vocation based.

Friday

7:05 am-8:00am	Wake-up, Dress, Wellness(morning exercise)
8:05 am-8:40am	Personal Hygiene, morning chores
8:45 am-9:05 am	Breakfast
9:05 am-9:30 am	Group Discussion
9:30 am-11:00 am	Education
11:05 am-12:00 pm	Educational Exploratory(could include educational films, tv programs, etc.)
12:05 pm-12:35 pm	Lunch
12:35 pm-12:55 pm	Arts and Crafts
1:00 pm-2:00 pm	Education
2:05 pm-2:45 pm	Drop Everything and Read
2:50 pm -3:25 pm	Individual Choice/Free Time(Overall Weekly Progress towards Butterfly Plan is discussed individually with the Executive Director during this time)
3:30 pm-4:35 pm	Quiet Time(includes individual snack)
4:35 pm-5:00 pm	House Meeting(Discuss possible program changes, food preferences, etc.)
5:05 pm-5:55 pm	Study Hall(Client phone calls also take place during this time)
5:55 pm-6:30 pm	Dinner
6:30 pm-7:25 pm	Indoor/Outdoor Recreational Activities
7:30 pm-8:00 pm	Self Reflection
8:00 pm-8:15 pm	Snack
8:15 pm-8:45 pm	Bedtime Preparation
9:00 PM	Bedtime

Client Daily Activity Schedule

Saturday

7:15 am-8:00 am	Wake-up, Dress, Health & Wellness
8:00 am-8:30 am	Personal Hygiene, Morning Chores
8:35 am-9:05 am	Breakfast
9:05 am-10:00 am	Weekly Room Cleaning
10:05 am-10:35 am	Group Discussion
10:40 am-1:00 pm	Structured Recreational Activities
1:05 pm-1:35 pm	Lunch
1:40 pm-2:35 pm	Drop Everything and Read
2:40 pm-3:25 pm	Client Individual Choice/Hobbies
3:30 pm-4:30 pm	Quiet Time(includes individual snack)
4:35 pm-5:55 pm	Recreational Activities
6:00 pm-6:35 pm	Dinner
6:35 pm-7:05 pm	Indoor Activities :
7:05 pm-9:10 pm	Group Movie
9:10 pm-9:30 pm	Bedtime Preparation
<i>Based on the level the client has achieved on the Butterfly Plan, out of facility activities and therapeutic leave occur on Saturday.</i>	

Sunday

7:15 am-8:00 am	Wake-up, Dress, Health & Wellness
8:00 am-8:30 am	Personal Hygiene, Morning Chores
8:35 am-9:05 am	Breakfast
9:05 am-10:00 am	Religion Expression/Free Time
10:05 am-10:35 am	Group Discussion
10:40 am-1:00 pm	Recreational Activities
1:05 pm-1:35 pm	Lunch
1:40 pm-2:35 pm	Drop Everything and Read
2:40 pm-3:25 pm	Indoor Activities
3:30 pm-4:30 pm	Quiet Time(includes individual snack)
4:35 pm-5:25 pm	Recreational Activities
5:30 pm-6:00 pm	Dinner
6:05 pm-7:05 pm	Indoor Activities
7:05 pm-9:10 pm	Group Movie
9:10 pm-9:30 pm	Bedtime Preparation
*1:00 pm-5:00 pm	Client Visitation

NEW HORIZON GROUP HOME

[REDACTED] Lumberbridge NC, 28357

April 25, 2018

The Curriculum Specialist
Public Schools of Robeson County

Dear Sir/Madam,

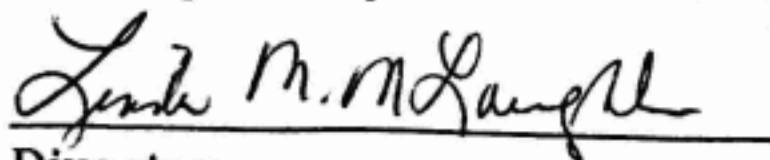
RE: Request of Approval of Homeschool Curriculum
New Horizon Group Home

Enclosed is the outline of the curriculum implemented by New Horizon Group Home. We provide services for school age students placed in the upper elementary level through the high school level in a residential facility.

Our curriculum is based on the skills and knowledge outlined in the North Carolina Public Schools Standard Course of Study for the core subjects of Reading /English/Language Arts; Mathematics; Science, and Social Studies. Our instructors and teachers and educational consultants are trained, certified and experienced in working in the North Carolina Public School system. The instructional methods, activities and resources are recommended and/or approved by the Department of Public Instruction.

We hope you find all the relevant indicators in this working document to grant approval of its use with our students. We are continuing to revise the content as updates and revisions are made to the state's Standard Course of Study.

Thank you for your consideration.



Director

New Horizon Group Home


Public Schools of Robeson County

North Carolina County of Robeson

Contract: 0002

Linda M. McLaughlin
services /Hold Harmless Agreement included

And New Horizon Group Home, LLC for educational

This agreement dated the 2.2.2018, by and between Linda M. McLaughlin
from this point named Educational Teacher and New Horizon Group Home, LLC, from this point named as
AGENCY. Whereas the Educational Teacher and the AGENCY enter into an agreement whereby Educational
Teacher shall provide Educational Teacher services for the AGENCY. The terms and conditions of the services to
be provided are as follows:

1. AGENCY AND EDUCATIONAL TEACHER mutually hereby indemnify and hold both parties harmless for any and all claims, demands, lawsuits, liabilities to include, but not limited to contract negligence, personal injury, property damage, criminal liability, etc. the same to include the payment of any and all attorney fees and costs. With regard to the services to be performed by the EDUCATIONAL TEACHER pursuant to the terms of this agreement, the EDUCATIONAL TEACHER shall not be liable to the AGENCY, or to anyone who may claim any right due to any relationship with the Corporation/AGENCY, for any acts or omissions in the performance of services on the part of the EDUCATIONAL TEACHER or on the part of the agents or employees of the EDUCATIONAL TEACHER, except when said acts or omissions of the EDUCATIONAL TEACHER are due to willful misconduct or gross negligence. The AGENCY shall hold the EDUCATIONAL TEACHER free and harmless from any obligations, costs, claims, judgments, attorney's fees, and attachments arising from or growing out of the services rendered to the AGENCY pursuant to the terms of this agreement or in any way connected with the rendering of services, except when the same shall arise due to the willful misconduct or gross negligence of the EDUCATIONAL TEACHER and the EDUCATIONAL TEACHER is adjudged to be guilty of willful misconduct or gross negligence by a court of competent jurisdiction.
2. **Responsibilities: EDUCATIONAL TEACHER** shall be to provide as requested by AGENCY the following services and contract deliverables:
 - a. **To provide the educational services within the facility to maintain the educational and intellectual development of the consumers residing in the Level IV facility by coordinating with the local education agency to ensure that the consumer's educational needs are met as identified in the education plan.**
 - b. **An Educational Plan (IEP) shall be developed for each of the consumers coordinated by the contract Education Service staff person and the local education agency.**
3. **Responsibilities of AGENCY** shall be to provide:
 - a. Work space that meets confidentiality of the consumers
 - b. Electronic (computer) with Internet access, if needed
 - c. Access to other office equipment i.e., printer, copier, fax, etc.

4. Period of Performance:

a. Begin date: 2.2.2018

c. This agreement is effective on the above date entered into and will terminate upon satisfactory completion of agreed upon services. AGENCY and EDUCATIONAL TEACHER may terminate this agreement without cause upon thirty (30) days written notification to the other party at the addresses shown in this agreement. AGENCY may terminate this agreement immediately upon EDUCATIONAL TEACHER'S refusal to, or inability to perform under the agreement or EDUCATIONAL TEACHER'S breach of this agreement. Further, this agreement shall be terminated automatically in the event of EDUCATIONAL TEACHER'S death. On termination of this agreement, AGENCY'S obligation to pay EDUCATIONAL TEACHER, except for services already accrued or incurred, will forthwith cease and terminate. Upon completion or termination of performance period, all deliverables will be provided to AGENCY upon satisfactory payment of service.

5. Place of Performance:

a. Level IV Residential facility site [REDACTED] Lumber Bridge N C

6. Payment:

a. Is due at completion of each contract service month; end of the contracted performance period or upon termination of service.

b. Payment for services at a rate of \$ _____ per hour;

7. Confidentiality:

a. The parties hereto acknowledge that during the course of EDUCATIONAL TEACHER'S service to AGENCY pursuant to this agreement, it will become necessary or desirable for AGENCY to disclose to EDUCATIONAL TEACHER a substantial amount of AGENCY Proprietary Information. EDUCATIONAL TEACHER fully understands that the maintenance of such information in strict confidence and the confinement of its use to AGENCY is of vital importance to the AGENCY. EDUCATIONAL TEACHER agrees that the information and knowledge divulged to the EDUCATIONAL TEACHER by AGENCY or which EDUCATIONAL TEACHER acquires in connection with or as a result of EDUCATIONAL TEACHER'S services hereunder will be regarded by EDUCATIONAL TEACHER as confidential;

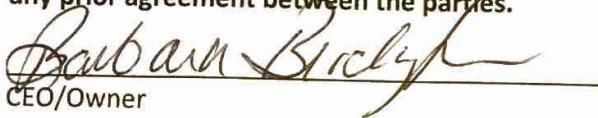
b. EDUCATIONAL TEACHER recognizes that all records and copies of records touching AGENCY'S operations, investigations and business made or received by EDUCATIONAL TEACHER during the period of this agreement are and will be the exclusive property of AGENCY, and EDUCATIONAL TEACHER will keep the same at all times in EDUCATIONAL TEACHER'S custody and subject to EDUCATIONAL TEACHER'S control, and will surrender the same to AGENCY immediately upon the request of AGENCY, or upon completion to agreed upon services.

8. Neither party to this agreement may assign, sell or transfer any part of this contract to any other firm or entity without first obtaining the written permission of the other party hereto.

9. This agreement has been negotiated, executed and delivered in the State of North Carolina. The parties hereto agree that all questions pertaining to the validity and interpretation of this agreement will be determined in accordance with the laws of the State of North Carolina.

10. Arbitration. Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration in accordance of the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) shall be entered in any court having jurisdiction thereof. For that purpose, the parties hereto consent to the jurisdiction and venue of an appropriate court located in County, State of North Carolina. In the event that litigation results from or arises out of this Agreement or the performance thereof, the parties agree to reimburse the prevailing party's reasonable attorney's fees, courts costs, and all other expenses, whether or not taxable by the court as costs, in addition to any other relief to which the prevailing party may be entitled. In such event, no action shall be entertained by said court or any court of competent jurisdiction if filed more than one year subsequent to the date the cause(s) of action actually accrued regardless of whether damages were otherwise as of said time calculable.

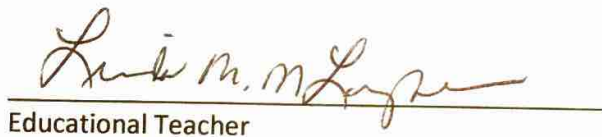
This agreement and referenced attachments constitute the entire contract of the parties hereto and supersedes any prior agreement between the parties.


CEO/Owner

2.2.18
Date

Barbara Brockington
Printed Name

2.2.18
Date


Educational Teacher

2.2.2018
Date


Witness

2-2-2018
Date

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2018
--	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON GROUP HOME, LLC

LUMBER BRIDGE, NC 28357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on April 13, 2018. The complaint was substantiated (Intake ID # NC00137426). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children or Adolescents.</p> <p>Summary Suspension issued on 04/11/18.</p>	V 000		
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <p>(1) general organizational orientation;</p> <p>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</p> <p>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</p> <p>(4) training in infectious diseases and bloodborne pathogens.</p> <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,</p>	V 108		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Barbara Bakington

CEO/OWNER

5-04-18

STATE FORM

6899

8ZNI11

If continuation sheet 1 of 116